Accessibility and Utilization of HIV and AIDS Services Evaluated

This Empowerment Evaluation stimulated measurements of Indicators and or associated factors related to Accessibility and Utilization of HIV and AIDS Services for People Living with HIV/AIDS in Sierra Leone. The research investigated a broad spectrum of Care, Treatment and Support Services and programs for PLWHAs using structured questionnaires by category; results disaggregated by demographic characteristics, using the Census and Surveys Program software and Statistical Package for Social Scientists for data entry and analysis. Data was also extracted from the organization records. In this thesis, I explored cross-tabulation and matching techniques using the demographic data of respondents to that of a range of services for PLWHAs, spanning from causes and incidence of Infection, on ART treatment, distance and time covered to service delivery points or clinics, means of transportation, satisfaction of medical and socio-economic services received by PLWHAs, such as VCCT, PMTCT, ART, STI, Condom, OVC, TB, FP, HBC, food and nutrition, vocational training, legal services, housing, clothing support, sponsorship, and recreational services, all weighted by levels of satisfaction.

James Maada L. Kamara, aka SuperMaadox was born in the Pujehun government hospital from parents, the late Dispenser J. L. Kamara aka Uncle Kay (RIP Dad), and Mrs. Fatmata M. Kamara aka Aunty Kay's. James is a catholic and blessed with three children, James Nyakeh, Andrew Maada and Bartholomew Abdulrahman. James holds a Master's in Public Health.

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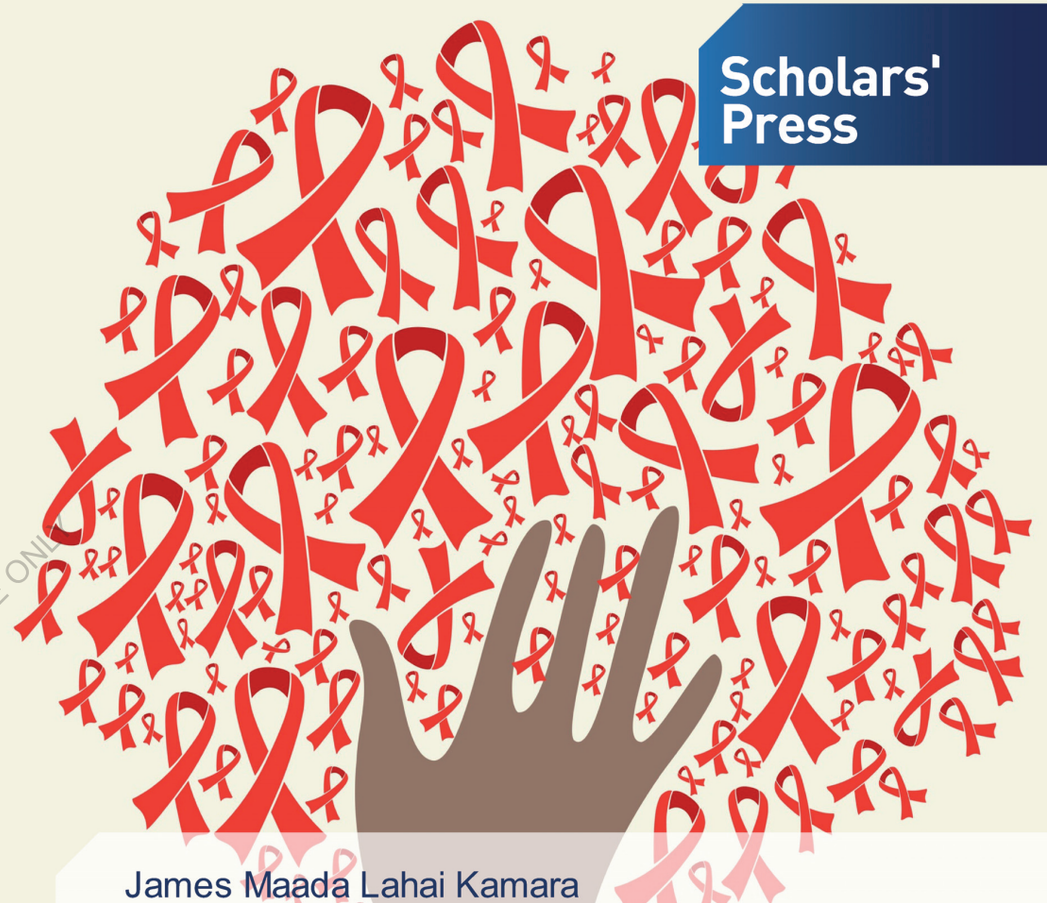

James Maada Lahai Kamara

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A Comprehensive Research Methodology on Evaluating HIV and AIDS Programmatic Interventions

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DEDICATION

To my late loving father, Dispenser James Lahai Kamara who taught me the value of discipline and hard work, my late grandmothers, Mama Fodie Watta Koroma and Madam Hawa Lumeh, my late step-mother, Madam Jabbeh Kamara (nee) Jah and my late professional and social godfather, Dr. Haroun Rashid Thuray a.k.a. Kabila, gone but not forgotten. **R.I.P**

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ABBREVIATIONS / ACRONYMS

AIDS ……Acquired Immune Deficiency Syndrome

ART…..……Anti-Retroviral Treatment

ARG …….AIDS Response Group

ARV…..……Anti-Retro Viral

CDC……..Centers for Disease Control and Prevention

CHO(s) ……..Community Health Officer(s)

CSPro……..Census and Surveys Program

CSW(s) …….Commercial Sex Worker(s)

CTS……Care, Treatment and Support

DFID ……Department for International Development

HBC ……Home Based Care

HIV……Human Immunodeficiency Virus

IDU ……Intravenous Drug Users

IGA ……...Income Generating Activity

MARPs ……...Most-at-Risks Populations

MCSL ……Methodist Church Sierra Leone

MDG ……...Millennium Development Goal

MOHS ……Ministry of Health and Sanitation

MSM ……..Men who have Sex with Men

N……Number

NACP ……...National AIDS Control Programme

NGO ……Non-Governmental Organisation

NAS ……National HIV/AIDS Secretariat

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OVC…….Orphans and Vulnerable Children

P/H ……..Public Health

PLWHAs ……..People Living with HIV/AIDS

PLHIVs ……..People Living with HIV

PMTCT ……..Prevention of Mother to Child Transmission

SECHN(s) ……State Enrolled Community Health Nurse(s)

SHARP ……..Sierra Leone HIV/AIDS Response Project

SLDHS ……Sierra Leone Demographic and Health Survey

SPSS ……..Statistical Program for Social Scientists

SSL ……Statistics Sierra Leone

STI ……..Sexually Transmitted Infections

TB……..Tuberculosis

UN ……United Nations

UNAIDS ……United Nations Program on HIV/AIDS

UNICEF ……United Nations Children's Fund

US ……United States

VCT ……...Voluntary Counseling and Testing

WB ….....World Bank

WHO……..World Health Organization

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DEFINITION OF KEY TERMINOLOGIES

HIV- stands for Human Immunodeficiency Virus. HIV is a germ that attacks human beings and weakens their bodies' ability to fight off other germs that cause illnesses and infection.

AIDS - stands for Acquired Immuno Deficiency Syndrome. AIDS is a final stage of the HIV infection. HIV destroys the person's ability to fight off germs and other causes of disease so that he/she is inflicted by ill-health. The period between HIV infection and development of illness takes about 2-15 years (WHO, 1997). Scientifically, AIDS also refers to a progressive immune deficiency caused by CD4+ T cells with the human immunodeficiency virus (HIV).

Care, Treatment and Support - Using the existing care, treatment and support frameworks of the World Health Organisation (WHO) and the United Kingdom's Department for International Development (DFID), a practical model of a comprehensive approach to care, treatment and support within a "continuum of care" was developed.

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This model includes curative and palliative care, psychological support and material help for PLHWAs and those affected. It also involves the support of people in the public, private and community sectors, families, friends, and professionals. The specifics of this model, including but not limited to anti-retroviral drugs, treatment of opportunistic infections, palliative and psycho-social care, improved healthcare systems, voluntary counseling and testing, strengthening communities to support PLWHAs, prevention of services and human rights, all of the above defines clearly the expectations of PLWHAs in addressing their care, treatment and support interventions, which this thesis is focused to investigate and to establish the levels of *accessibility* and *utilization* of services provided or to be provided to PLWHAs in Sierra Leone.

Accessibility: In general terms, "access" means the ability to get care or the ease of getting care. Penchansky (2001, p.1) explained that access to health and other health related services including

care, treatment and support services for people living with HIV/AIDS must capture the relationships between supply / suppliers and demand / demanders in the following five dimensions:

i. **Availability** – the quantity and types of population needs relative to the volume and type of existing services.

ii. **Accessibility** – the relationship between the location of supply and the location of users, taking into account the user transportation resources and travel time, distance and cost. According to the comprehensive primary health care service package for South Africa (2001), geographical accessibility means that the distance, traveling time and means of transport must be acceptable to the community. Access is measured by the population of people living within 5km of a clinic or service provision point.

iii. **Accommodation** – the way resources are organized for entry – hours of operation, waiting time, scheduling systems, walk-in facilities and the existing client's ability to be accommodated by these.

iv. **Affordability** – the resources (income, health benefits) for purchasing care related to the price / cost of the supply.

v. **Acceptability** – the social / cultural concerns – attitudes on religion, gender, race, neighborhood, tribe of patients and providers as they relate to the attributes of each other. It is believed that all these factors affect supply and demand and have influence on utilization of health services in general (Penchansky, 2001, p.1) and in particular HIV/AIDS care, treatment and support services for PLWHAs.

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Utilization: This provides the knowledge of whether the available services are being used and also if the different services provided are being utilized. To determine if the care, treatment and support services provide efficient care, then it will be presumed that the care, treatment and support services of the PLWHAs will be improved.

Other relevant terms

Adherence to ART - is taking all ARV pills in the correctly prescribed doses at the right time and in the right way observing any dietary restriction.

Age - this refers to the number of years that an individual has lived since date of birth.

CD4+ - this refers to an antigen maker of helper / inducer T cell that recognizes antigens bound in class II MHC protein.

Co-treatment - treatment of two or more infections simultaneously.

Incidence - the incidence of a disease is defined as the number of new cases that occurs during a specified period of time in a population at risk for developing the disease.

Optimal adherence - proportion of those who take their medication ≥ 95% of the time.

Sub-optimal adherence - proportion who take their medication <95% of the time.

Prevalence - this refers to the number of affected persons present in the population at a specific time divided by the number of person in the population at that time.

Undetectable viral load - virus not detected in the blood after a laboratory test.

Viral load - levels of virus found in the blood per 10 milliliters (mls).

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ABSTRACT

On the cusp of the third decade of the AIDS pandemic, the world has turned the corner; it has halted and begun to reverse the spread of HIV (Millennium Development Goal 6, Target 7). The question remains how quickly the response can chart a new course towards UNAIDS' vision of zero discrimination, zero new HIV infections, and zero AIDS related deaths through universal access to effective HIV prevention, care, treatment and support for PLWHAs, their families, communities and nations . The accessibility and utilization of care, treatment and support services as a mitigating measure against the high mortality and related morbidities is undermined or strangulated by service providers at different levels. Children become orphans due to the outcome of HIV/AIDS.

A structural questionnaire was used to collect data at the service delivery points and clinics from to beneficiaries of the NGO, Methodist Church Sierra Leone, who provides care, treatment and support services for some people living with HIV/AIDS in the Western Area of Sierra Leone. Document review of the organization's records was conducted to investigate the utilization trends in term of service provision against access and utilization. Descriptive statistics was used to present the results and findings. The analysis was based on the information elicited from the questionnaire administered. Census and Surveys Program software (CSPro.) and Statistical Package for Social Scientists (SPSS Version – 18) were used for data entry and analysis. Data extracted from the organization records was also used.

With regards to accessibility, PLWHAS were investigated to establish distances covered or travelled to reach a clinic or service delivery point. The findings indicated that people living with HIV/AIDS are less accessible to the service delivery points or clinics as most participants, 50 of the 97 lived within or travelled some 5-10 km radius to get the clinic or service delivery points

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(51.5% of the study population), 34 of the 97 respondents (35.1%) lived within or travel some 10km or more to get the clinic or service delivery points.

Generally, PLWHAs were not satisfied with the services provided as revealed from the analyzed cross-tabulated data. Satisfaction was measured against the UNAIDS and WHO universal standards set for care, treatment and support needs of PLWHAs. In the case of financial support to PLWHAs, the levels of satisfaction were disaggregated as follows: very dissatisfied had 2 respondents, one each by gender; dissatisfied had 6 of which 2 male and 4 female, and only 3 expressed satisfaction, of which 2 were male and 1 female of the 23 out of 97 who demanded financial support. For the services of food and nutritional support, of the 56 out of the 97 who demanded this service, 45 expressed some levels of satisfaction as follows: dissatisfaction expressed by 11 males and 10 females, totaling 21 (21.6%) and satisfaction expressed by 12 males and 12 female totaling 24 (24.7%). Scaling the TB treatment, satisfaction levels were not encouraging, as results reveal the following: of the 13 out of the 97 PLWHAs who demanded TB services, 10 expressed dissatisfaction of which 6 were males and 4 females, and only 3 expressed satisfactions; 2 males and 2 females.

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Based on the research results, care, treatment and support services are not fully accessible and utilized effectively against the backdrop of interventions or services required by the PLWHAs and provided by the facilities. In that regard, would recommend conducting a separate in-depth study to include both qualitative and quantities methods in order to know or establish reasons for poor utilization and accessibility of services and to also determine the impact at national level with a large sample size targeting local and international non-governmental organizations and hospital/clinic facilities of both the public and private sectors providing these in Sierra Leone

CHAPTER ONE

1. INTRODUCTION

1.1 Introduction and background of the study against the Global Pandemic.

The incidence of HIV/AIDS is an eyesore to sustainable global order, indeed sub-Saharan Africa's development. It is needless to say millions of people across the world are threatened every minute by a wide range of social problems – poverty, illiteracy, gender bigotry, conflict, drug abuse, addiction and trafficking, human trafficking, sexually transmitted infections including human immunodeficiency virus (HIV) and its advanced stage, acquired immune deficiency syndrome (AIDS).

The world has been grappling with the HIV/AIDS pandemic for close to three decades now. Since 1999, the year in which it was thought that the epidemic peaked, globally, the number of new infections has fallen by 19%. Of the estimated 15 million people living with HIV in low and middle –income countries who need treatment today, 5.2 million have access—translating into fewer AIDS-related deaths.

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Tables 1: Comparative Outlook of the Global Pandemic

		Adults and Children living with HIV	Adults and children newly infected with HIV	%age of adults prevalence (15-49 yrs)	AIDS-related deaths among adults and children
Sub-Saharan Africa	**2009**	22.5 million	1.8 million	5.0	1.3 million
	2001	20.3 million	2.2 million	5.9	1.4 million
Global	**2009**	33.3 million	2.6 million	0.8	1.8 million
	2001	28.6 million	3.1 million	0.8	1.8 million

Source: UNAIDS 2010 Global report

UNAIDS estimates that there were 33.3 million [31.4 million-35.3 million] people living with HIV at the end of 2009 compared with 26.2 million [24.6 million-27.8 million] in 1999, which indicates

a 27% increase. Although the annual number of new infections has been steadily declining since the late 1990s, this decrease is offset by the reduction in AIDS-related deaths due to the significant scale up of antiretroviral therapy over the past few years. The report also indicates the estimated number of children living with HIV increased to 2.5 million and the proportion of women living with HIV has remained stable, at slightly less than 52% of the global total.

1.2 The Sub-Saharan Africa and Sierra Leone Picture.

Sub-Saharan Africa still bears an inordinate share of the global HIV burden. Although the rate of new HIV infections has decreased, the total number of people living with HIV continues to rise. In 2009, that number reached 22.5 million, 68% of the global total. Sub-Saharan Africa has more women than men living with HIV.

The largest epidemics in sub-Saharan Africa are in Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe, have either stabilized or are showing signs of decline. The estimated 1.3 million people who died of HIV related illnesses in sub-Saharan Africa in 2009 comprised 72% of the global total of 1.8 million deaths attributable to the epidemic.

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The response against the pandemic has been overwhelming worldwide. There has been concerted and higher level action than ever before in response to the HIV/AIDS pandemic in the world. Most governments have initiated HIV/AIDS prevention and treatment programmes which are helping to contain the pandemic and also prolong the lives of those infected with the disease. However despite these initiatives there are challenges. Care, treatment and support services for people living with HIV/AIDS often pose major challenges to the successful implementation of the overall HIV/AIDS programmes.

The impact of HIV worldwide will be felt for decades to come. Promising developments have been seen in recent years in global efforts to address the AIDS pandemic, including increased access to effective care, treatment, support and prevention programmes (UNAIDS/WHO, 2006).

The accessibility and utilization of care, treatment and support services to infected and affected people with HIV/AIDS poses a significant challenge to the government of Sierra Leone, the National HIV/AIDS Secretariat (NAS) and its development partners. The development and implementation of a coordinated continuum of care, treatment and support encompasses a wide range of activities, many of which depend on the existence of a strong public / private health infrastructure and health care delivery systems. This burden falls mainly on the public sector as represented by the Ministry of Health and Sanitation (MOHS) and its health sector development partners.

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The strong stigma attached to HIV/AIDS remains the most serious impediment in developing an appropriate response to this issue. Lack of confidentiality contributes significantly to this problem and permeates at all levels of the public / private health care delivery systems.

In 2003/4 there were very few care, treatment and support options available for PLWHAs in Sierra Leone. HIV/AIDS specific services were extremely limited in the western region (mostly in the private sector) and non-existent in the other provincial regions. Treatment for related conditions and co-morbidities such as STIs and TB was generally available, and needed to be promoted and enhanced as part of the continuum of care for infected individuals.

With regards to this research, the continuum of care, treatment and support for PLHWAs begins with their first inquiry and carries on to meet as many of their needs as possible, finishing up with care, treatment and support to their families after death.

The continuum is defined not only by the range of services it encompasses – counseling and information, clinical care and treatment, home care and family counseling etc – but also by the common quality that links together and strengthens service delivery. This quality comes from the attitudes and values of the careers and from the dignity and trust of the people living with HIV/AIDS. The individual needs of PLWHAs and their families shape service delivery. As a result, the energy of caring is equally shared among care-givers, people with HIV, and their families and communities. PLWHAs, family members, doctors, counselors, nurses, nutritionists, educators, laboratory technicians, administrators and support staff can all contribute to care, treatment and support services. Through contributing, they are changed and the care, treatment and support they give to others are made more effective. The effects of HIV infection are different for each PLWHA and each family, the continuum provides a supportive framework, in which these different needs can be recognised and addressed as they arise.

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1.3 Objectives of the HIV/AIDS care, treatment and support in Sierra Leone

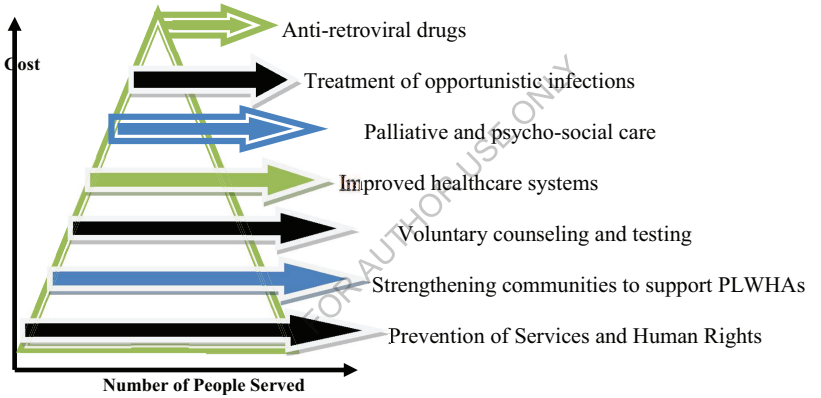
According to the national HIV/AIDS policy, January, 2002, the general objectives of care, treatment and support for people living with HIV and AIDS are:

- To reduce mortality and morbidity among the PLWHAs and the general population in Sierra Leone.
- To improve the quality of life of persons living with and affected by HIV/AIDS.
- To increase the accessibility and utilisation of care, treatment and support facilities
- To strengthen the technical capacity of PLWHA care providers at all levels of the health care delivery system
- To strengthen referral services for PLWHAs, particularly at the district level and with specific emphasis on appropriate referral of high risk cases

- To increase the availability and use of ARTs for all persons living with HIV
- To raise the awareness of the importance of the care, treatment and support of PLWHAs and in particular, those affected, their families, communities and the nation
- To improve the legal and socio-economic status of PLWHAs

All of the above can be summarized in the modal designed below to accomplish a comprehensive approach to care, treatment and support for PLWHAs in Sierra Leone.

Figure 1: A model of comprehensive approach to CTS for PLWHAs in Sierra Leone: (The cost *and complexity of aspects of CTS against the number of PLWHAs served)*



(Cost benefit pyramid of HIV/AIDS care, treatment and support services).

The National HIV/AIDS Secretariat's organisational mission, vision and values emphasize attention to areas such as human rights, care, treatment and support to vulnerable populations. This, combined with the experiences of the UNAIDS and other organisations who participated in the national consultations on scaling up towards universal access for HIV prevention, treatment, care and support in May 2006, compelled urgent attention to the area of care, treatment and support. Such experiences also demonstrated that something could be done – in terms of

appropriate and high quality efforts having multiple, tangible benefits for individuals, families, communities and the nation. As a result, the NAS community care, treatment and support initiatives should focus on getting basic care, treatment and support services to the poorest people in communities, with the aim of developing cost effective, sustainable approaches to improve quality of life and increase life expectancy. The NAS has been putting its policy commitment to community care, treatment and support into practice. But more still needs to be down, in the areas of where were we? Where are we? Where do we go? How do we close in the gaps if they exist? What is needed? How do we get what is needed? How do we utilize it properly and correctly? Etc. However the real story lies within the experiences and achievements in the NAS's key areas of work – mobilising action, enhancing quality, building capacity and sharing lessons learned.

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1.4 Objectives of the research / study

- To investigate whether the care, treatment and support services are accessible to the people living with HIV/AIDS in the Methodist Church Sierra Leone (MCSL) HIV/AIDS program in the western area of Sierra Leone.
- To determine care, treatment and support services utilization in the Methodist Church Sierra Leone (MCSL) HIV/AIDS program rendering these services to people living with HIV/AIDS in the western area of Sierra Leone
- To make recommendations to policy makers, programme managers based on the findings.

1.5 Justification of the research

Whilst there is literature from other parts of the world, in Sierra Leone there is an information gap on the issue of HIV/AIDS care, treatment and support for PLWHAs with regards to accessibility and utilization of services provided at both the health facilities and other service delivery channels hence there is need to explore whether there are problems relating long waiting times, lack of

resources like medication, travelling time to facilities, means of transportation, other socio-economic factors and what form they take at those levels or facilities. The findings from the study will add to the literature on the topic area. They research findings may also give guidance to policy makers responsible for HIV/AIDS care, treatment and support interventions and help to improve approaches for motivating facilities to become more PLWHA care, treatment and support-friendly through improved policies and services.

1.6 Hypothesis of the research / study

- People living with HIV/AIDS are more likely to use care, treatment and support services in 2010 Compared to 2004 in Sierra Leone
- People living with HIV/AIDS who travel less than 5km to a clinic or service delivery point are more likely to use care, treatment and support services
- People living with HIV/AIDS who take 30 minutes or less to visit a facility are more likely to use care, treatment and support services
- People living with HIV/AIDS who use taxis as a means of transportation are more likely to access care, treatment and support services
- People living with HIV/AIDS who are employed and earn in cash or in kind are more likely to use care, treatment and support services

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1.7 Research questions

- Are care, treatment and support services in the Methodist Church Sierra Leone (MCSL) HIV/AIDS program in the western area accessible for PLWHAs?
- What is the extent of utilization of these services by the PLWHAs?

1.8 Research problem

The HIV/AIDS pandemic is one of the most serious socio-economic, political, cultural, and demographic and health and health related problems and concerns in Sierra Leone today. This is as a result of its high case-fatality rate and the lack of a cure or "permanent cure". Comprehensive knowledge about AIDS is very low, only 14% of women and 25% of men age 15-49 years measured those levels which implies that concerted effort is needed to address misconceptions about the transmission of HIV in Sierra Leone. A composite indicator on stigma towards people who are HIV positive shows that only 5% of women and 15% of men age 15-49 expressed accepting attitudes towards persons living with the virus. These are critical concerns for research. Regarding condom use, only 7% of women who had more than one partner in the 12 months before the SLDHS-2008 survey said they used a condom during the most recent sexual intercourse, far lower than the 15% reported by men. Among women who reported having higher-risk sexual intercourse in the past 12 months, only 7% used a condom at the last higher-risk sexual intercourse. For men, the comparable figure is three times higher (22%).

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Overall, only about one-quarter of women age 15-49 years and one-third of men age 15-49 know where to get an HIV test. Even fewer have ever been tested; only 13% of women and 8 % of men have ever had an HIV test, and only 4% of women and 3% of men have been tested and received their test results in the 12 months before the survey, (SLDHS-2008)

The survey results indicated that overall, 1.5% of the Sierra Leone population of adults aged 15-49 were HIV positive. HIV prevalence was slightly higher among women (1.7%) than men (1.2%). All of the above are challenging and require critical thinking and attention to address.

1.9 Significance of the study in Sierra Leone

The Sierra Leone HIV/AIDS Response Project (SHARP) 2007/8, and the Global Funds to fight HIV/AIDS Round (4) 2008/9, had completed the first phases of their program implementation

during the stated times above, As a result, questions needed to be answered as to how and at what levels have interventions supported, lessened the burden of HIV/AIDS from those infected and affected by the condition / disease? And to investigate the levels of accessibility and utilization of the care, treatment and support services for people living with HIV/AIDS. Impact mitigation studies have shown to make important and useful contribution to informing how effective the national response is or not to HIV, as well as mapping policy directions.

They findings of this study will assist the government, NAS and its development partners, local and international NGOs to unite and develop more strategic plans for care, treatment and support interventions for people living with HIV/AIDS and to mitigate its impact in the country. The people that are already infected and affected by HIV/AIDS would benefit from the study by adopting a positive living that would possibly help them fight back from their disastrous situations.

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1.10 Conclusions on chapter one

The Chapter gave a clear picture of the current global pandemic, with objectives of care, treatment and support (CTS) services in Sierra Leone. It also illustrated a comprehensive model on the approach of CTS in Sierra Leone and as looked at the objectives of the research, justifications, significance, hypothesis and the research questions. The next chapter would detail the literature reviews on the problem identified.

CHAPER TWO

2. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORKS

2.1 Introduction

Many studies have shown that People Living with HIV/AIDS face serious problems in accessing and utilizing care, treatment and support services rendered in health care facilities generally, and in particular, service provision points. Studies conducted in India and Mexico provides evidence that PLWHAs have, in extreme cases, been physically attacked or murdered in their communities. Stigma can lead to discrimination and other violations of human rights which affect the well-being of people living with HIV in fundamental ways. Violations of the rights of those living with HIV have been documented worldwide and have included denial of medical care, breaches of the right to privacy and discrimination in health institutions.

Under international law, governments are obligated to respect, protect, and fulfill the human rights of people vulnerable to HIV, those living with HIV/AIDS, and those affected by the disease.

This literature review takes into account both published and unpublished studies on the concept of care, treatment and support services and its accessibility and utilization in HIV/AIDS management. The literature was reviewed for global, sub-Saharan and Sierra Leone trends. Policy documents and studies on the practice of HIV/AIDS in Sierra Leone were also reviewed for their relevance to care, treatment and support for people living with HIV/AIDS. Through online searches, conference papers and various programme documents and reports from researchers on HIV/AIDS care, treatment and support were accessed and reviewed. A few sources on HIV/AIDS trends and manuals with clinical guidelines for care, treatment and support were reviewed to give the context for practice of care, treatment and support interventions; however, the focus of the review was on organization or delivery of services and less on the disease patterns.

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2.2 Current Epidemiological Outlook of HIV/AIDS Globally.

AIDS is a global catastrophe, threatening social and economic stability in the most affected areas, while spreading relentlessly into new regions. Since the beginning of the epidemic, almost 60 million people have been infected with HIV and 25 million people have died of HIV-related causes. In 2008, some 33.4 million people living with HIV, 2.7 million new infections and 2 million AIDS-related deaths.

In 2008, around 430 000 children were born with HIV, bringing to 2.1 million the total number of children under 15 living with HIV. Young people account for around 40% of all new adult (15+) HIV infections worldwide. Sub-Saharan Africa is the region most affected and is home to 67% of all people living with HIV worldwide and 91% of all new infections among children.

In sub-Saharan Africa the epidemic has orphaned more than 14 million children.

In the thematic area of prevention, the percentage of HIV-positive pregnant women who received treatment to prevent transmission of the virus to their child increased from 33% in 2007 to 45% in 2008. Also the 2008 data indicate that fewer than 40% of young people have basic information about HIV and less than 40% of people living with HIV know their status. The number of new HIV infections continues to outstrip the numbers on treatment—for every two people starting treatment, a further five become infected with the virus.

With regards to treatment, more than 4 million people in low-and middle-income countries had access to HIV treatment at the end of 2008, up from 3 million at the end of 2007. This represents an increase of 36% in one year and a 10-fold increase over five years. An estimated 700 000 people received treatment in high-income countries in 2008, bringing the global total to at least 4.7 million. Despite considerable progress, global coverage remains low: in 2008, only 42% of those in need of treatment had access (compared with 35% in 2007). In 2008, only 38% of children in need of treatment in low-and middle income countries received it. (UNAIDS, WHO updates, 2009)

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2.3 Epidemiology of HIV/AIDS in Sub-Saharan Africa.

The degree at which this social pathology (HIV) is spreading over sub-Saharan Africa is disturbing. Of particular interest HIV/AIDS has dominated contemporary public and private discourses. In most of the debates, the dangers of this scourge are spelt out, that the threat, which the spread of HIV/AIDS inflicted on the lives of more than hundreds of millions of people across the continents is greater than the panic that terrorist attacks and wars unleashed on them. What this means is that, if adequate measures are not taken, the catastrophic nature of HIV/AIDS will ground down the socio-economic activities of some countries, if not the whole sub-Saharan African socio-economic order.

Sub-Saharan Africa's epidemics vary significantly from country to country—with most appearing to have stabilized including Sierra Leone, although often at very high levels, particularly in southern Africa countries.

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The nine countries in southern Africa continue to bear a disproportionate share of the global AIDS burden—each of them has an adult HIV prevalence greater than 10%. With an adult HIV prevalence of 26% in 2007, Swaziland has the most severe level of infection in the world. Lesotho's epidemic seems to have stabilized, with a prevalence of 23.2% in 2008. South Africa continues to be home to the world's largest population of people living with HIV—5.7 million in 2007.

While the rate of new HIV infections in the region has slowly declined, the number of people living with HIV slightly increased in 2008, partly due to increased longevity stemming from improved access to treatment. Adult (15–49) HIV prevalence declined from 5.8% in 2001 to 5.2% in 2008. By the end of 2008, 44% of adults and children in the region in need of antiretroviral therapy had access to treatment. Five years earlier, the regional treatment coverage was only 2%.

In East Africa, HIV prevalence seems to have stabilized and in some settings may be declining. In Burundi, HIV prevalence fell among young people aged 15 to 24 in urban areas between 2002 and 2008 (4% to 3.8%) and in semi-urban areas (6.6% to 4%) during the same period, while HIV prevalence increased in rural areas from 2.2% to 2.9%.

Although HIV prevalence in West and Central Africa is much lower than in southern Africa, the sub region nevertheless is home to several serious national epidemics in countries such as Côte d'Ivoire (3.9% HIV prevalence) and Ghana (1.9% prevalence).

2.4 Background and situation of HIV/AIDS Epidemiology in Sierra Leone

Although the HIV/AIDS prevalence rate for Sierra Leone is lower than for other countries in the sub-Saharan region, the potential exists for an explosive increase in the transmission of HIV as a result of these vulnerable groups: prison inmates, commercial sex workers, and men having sex with men, police, fisher forks, military, mobile or migrants and miners. Additional factors include the existence of poverty, the presence of large numbers of foreign troops in the country as a result of the civil conflict and other determinants for HIV transmission; such as high level of illiteracy, high risk sexual behaviour, multiple sexual partners, low condom use, high unemployment, increase rural- urban migration of youths and young adults and the breakdown to the extended family structure as a result of increase migration. Results from the 2008 SLDHS indicate that 1.5 % of Sierra Leonean adults age 15-49 have HIV. HIV prevalence in women age 15-49 was 1.7 %, while for men age 15-49, was 1.2 %. Prevalence peaks among women and men in age group 30-34 (2.4 % for women and 1.8 % for men).

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Table 2.1 Current Data on HIV/AIDS in Sierra Leone

No.	Indicator Definition	Indicators
1.	Population of Sierra Leone	About 5.6 million
2.	Adult HIV prevalence	About 1.5%
3.	HIV prevalence among pregnant women	3.2%
4.	%age HIV prevalence between 2002 & 2005,	50% Increased (0.9 to 1.5%)
5.	Number of HIV positive in the general population	About 50,000
6.	Number of new infections per year	About 6000
7.	Number of AIDS deaths per year	About 3500
8.	%age of Patients on ART who survive after 12 months of initiation	84%
9.	%age of infants born to HIV positive mothers	9%
10.	%age of HIV Response Programmes funded externally	97%
11.	%age of PLHIV who have TB (co-infection); 20.7% men and 7.27 women	14.4%
12.	Comprehensive knowledge about HIV & AIDS	Women=14% ; Men =25%
13.	Mean age at first marriage	Women =17 ; Men=25
14.	Mean age at start of sexual relations	Women =16 ; Men=19
15.	%age of young people who had sexual intercourse before the age of 15	Girls =24% ; Boys=11%
16.	3% women and 7% men used condoms @ first sexual encounter	Young women =3% Young men=7%
	Other related indicators	
17.	Mean of sexual partners in life time among women and men 15-49 yrs is 2 and 7	
18.	5% of women and 21% of men have more than one sexual partner	
19.	Adults in risky sexual behaviour, 7% of women and 15% of men use condoms	
20.	14% of IDUs in Freetown & 47% share needles & syringes	
21.	1.6% IDUs among CSWs, 87% share needles and syringes	

Source: UNAIDS, Sierra Leone March, 2011. Modes of transmission and new National Strategic Plan for HIV, 2011-2015

Table 2.2 HIV Prevalence by various MARPs & clients in Sierra Leone

No.	Population Group	HIV Prevalence / Infected
1.	General Population	1.5%
2.	Prison Inmates	9.7%
3.	CSW	8.5%
4.	MSM	7.5%
5.	Police	5.8%
6.	Fisher folks	3.8%
7.	Military	3.3%
8.	Mobile / Migrant	2.2%
9.	Miners	1.1%

Source: UNAIDS, Sierra Leone March, 2011. Modes of transmission and new National Strategic Plan for HIV, 2011-2015

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Table 2.3 Medical Personnel gap in 2008 in Sierra Leone

Personnel Cadre	Number of staff available		Gap
	In 1993	In 2008	
Medical Officers	203	78	222
Pediatricians	16	4	13
Dentists	15	8	12
Obstetricians/Gynecologists	23	8	7
P/H Superintendents	58	24	6
Surgeons	13	7	25
Physician Specialist	5	4	26
Mid-wives	132	87	213
State Registered Nurses	625	355	245
Laboratory Technicians	N/A	124	176
Pharmaceutical Technicians	N/A	127	273

Source: Revised National PHC Handbook, June 2004, National Health Sector Strategic Plan 2010-2015

Table 2.4 Health institutions during the 2006-2010 HIV/AIDS Strategic Plan

Health Institutions	2005/6	2010
Government Hospitals	45	30
Community Health Centers	193	178
Community Health Posts	256	176
Maternal and Child Health Posts	381	520

Source: Revised National PHC Handbook, June 2004, National Health Sector Strategic Plan 2010-2015

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Table 2.5 Health Personnel during the 2006-2010 HIV/AIDS Strategic Plan

Health Personnel	2005/6	2010
Medical Officers including Specialists	106	162
Community Health Officers	132	132
State Registered Nurses	308	245
Nurse Midwifes	42	95
Environmental Health Officers	122	135
SECHNs	712	635
Pharmacy Technicians / Dispensers	3	80

Sources: Sierra Leone Health Sector Review, 2004 Page51, MOHS- NHSSP, 2010-2015

2.4.1 Background to the Sierra Leone response

The HIV and AIDS program in Sierra Leone was established in 1987, this was as a result of the first diagnosis of the virus in a Sierra Leonean student deported from Russia. Prior to that time, government responded as a first step to the discovery of the virus (HIV) globally, by the formation of a National AIDS Committee in 1986. This Committee was then transformed into the National AIDS Control Programme (NACP) in 1988 to strengthen the HIV/AIDS prevention activities. The

main focus or objective then was to raise people's awareness of HIV/AIDS, but preventive and control activities were not given high priority, mainly because of the internal conflict, inadequate resources and low political commitment and advocacy. The situation however changed in 2001, when the Government recognized that HIV/AIDS was a developmental problem.

In 2001, the Government of Sierra Leone appointed a Cabinet Sub-Committee on HIV/AIDS under the leadership of the Minister of Information and Broadcasting. The Cabinet Sub- Committee collaborated with several development partners such as the UN Theme Group on HIV/AIDS, the World Bank and the US Government to establish structures that strengthened the national response to HIV/AIDS. Through this collaborative partnership, mostly with the expanded UN Theme Group on HIV/AIDS, a National Policy was drafted in 2001. Government also collaborated with the US Centre for Disease Control and Prevention (CDC) to conduct a National HIV Sero-Prevalence and Behavioural Survey in 2002 which provided a relatively clear status of the HIV/AIDS situation in the country.

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There was renewed interest and awareness leading to heightened activities to respond to the HIV/AIDS epidemic. A four-year project: Sierra Leone HIV/AIDS Response Project (SHARP) was formulated and supported / funded by the World Bank in 2002.

The Ministry of Health and Sanitation established, in October 2002, the AIDS Response Group (ARG) as the health sector's technical arm with four major areas of focus: surveillance, prevention, care and capacity building. In that context, combating HIV/AIDS was and is considered a major step towards poverty reduction.

In 2006, the world made a historic commitment at the United Nations to dramatically scale up the AIDS response. In the same year, 53 African countries met in Congo Brazzaville and adopted a broad list of 26 action recommendations which they hoped will help African countries towards

meeting the goal of universal access to HIV and AIDS treatment, prevention, care and support by 2010. The delegates represented governments, parliaments, civil society, faith based organizations and the private sector, Sierra Leone participated and made commitment.

This commitment became known as the Brazzaville commitment. The commitment is a milestone towards countries meeting the Millennium Development Goals especially MDG- 6 - Combat HIV/AIDS, Malaria and other diseases with Target 7, which challenges countries to halt and begin to reverse the trend/spread of HIV/AIDS by 2015.

2.5 Trend analysis of HIV/ AIDS epidemic in Sierra Leone

According to data from the ANC Sentinel Surveillance Reports (2006, 2007 & 2008) and 2008 SLDHS shows that HIV prevalence in urban areas is significantly higher than rural areas and the national average. HIV prevalence among pregnant women is declining steadily between 2007 and 2008, from 4.4% to 3.5%. A similar pattern is observed among urban women, where the HIV prevalence has declined from 4.9% to 4.6 in the same reference period. However, HIV prevalence has shown a three-fold increase among rural pregnant women, rising from 1.1% in 2007 to 3.3% in 2008.

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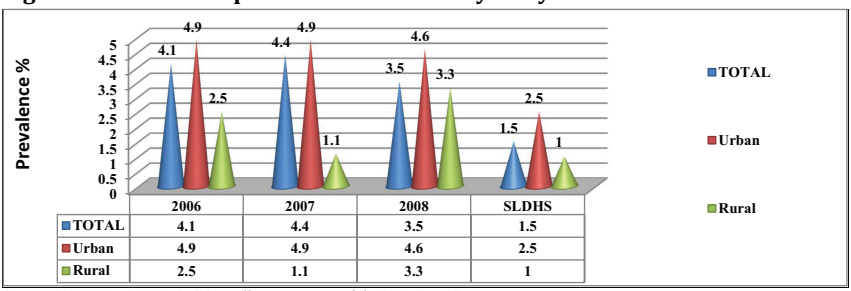
Figure 2.1 ANC HIV prevalence trend analysis by rural-urban residence

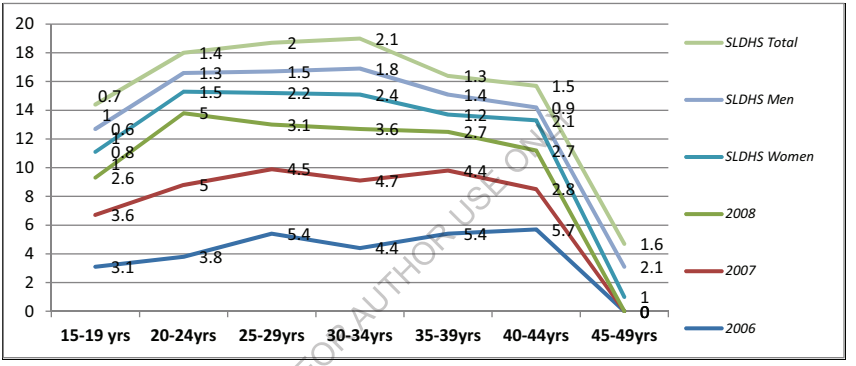


	2006	2007	2008	SLDHS
TOTAL	4.1	4.4	3.5	1.5
Urban	4.9	4.9	4.6	2.5
Rural	2.5	1.1	3.3	1

Source: 2006, 2007 & 2008 ANC Surveillance Reports and the 2008 SLDHS

Analysis of HIV prevalence by various age groups illustrated in figure 2.2 below indicates that the levels are lower among terminal age groups – 15-19 years and 45-49 years. HIV prevalence increases sharply between 15-19 years and 20-24 years. There is broad peak of HIV prevalence between 25 and 39 years, before stabilizing in the 40-44 years age group, and sharply declining in the 45 group. The burden and impact of HIV is much more in the prime and productive age groups 20-39 years.

Figure 2.2 HIV Prevalence by Age-group



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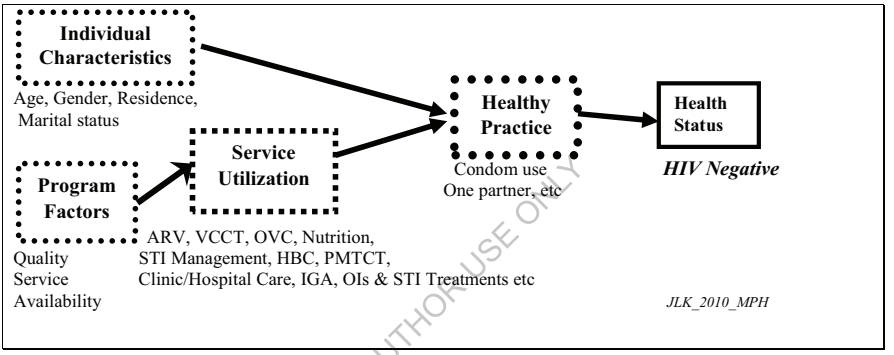
2.6 Conceptual framework for HIV/AIDS care, treatment and support program

Figure 2.3 below shows the general conceptual framework for care, treatment and support services. Figure reflects that ultimate goal of care, treatment and support program is to improve the health status of people living with HIV/AIDS. The intermediate result to achieve the goal is to increase the utilization of care, treatment and support services. Utilization of services depends on the supply and the demand of the available services. Implementation of the program, establishments of service delivery points, provision of human and logistic supplies and maintaining the quality of services are the supply side and are affected by financial resources, political commitment, policy formation

and legislation and regulation. While the individual demand and practice of the available care, treatment and support services are affected by socioeconomic and cultural factors. Demand and supply of the services affect utilization of care, treatment and support services very much. When the influence of these factors is positive then only the program has impact towards increasing utilization of services.

Figure 2.3 Conceptual Framework for the impact of HIV/AIDS on PLWHAs



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2.7 HIV/ AIDS care, treatment and support results framework

Figure 2.4 below shows the result framework of Care, Treatment and Support program in Sierra Leone. The objective, target and strategies for care, treatment and support program during 2006 to 2010 plan period were adopted according to the idea of long term care and support plan and the HIV/AIDS policy. Thus the care, treatment and support program goal, objectives and strategies in Sierra Leone have been converted to the results framework. Figure 2.4 reflects that evaluations can focus on different program components. Care, treatment and support can be viewed in terms of five distinct elements: the inputs, processes, outputs, outcomes and impact. Program inputs refer to the set of resources such as personnel, facilities, space, equipment and supplies. The processes refer to the set of activities in which program inputs are utilized to attain the results expected from

program. Outputs are the results obtained at the program level through the execution of activities using program resources. The program outcomes are the set of results expected to occur at the population level due to the program activities and the generation of program outputs. These are divided in to two components: intermediate outcomes and the long-term outcomes. In this result framework the intermediate outcome of care, treatment and support program is to increase the utilization of care, treatment and support services and is closely linked to program activities and program level results. Long term outcome refers to the set of results at the population level that are long-term in nature and are produced through the action of intermediate outcomes. Here the long term outcome is to improve the overall care, treatment and support services plus the health status of people living with HIV/AIDS.

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Fig 2.4 HIV and AIDS care, treatment and support program results framework

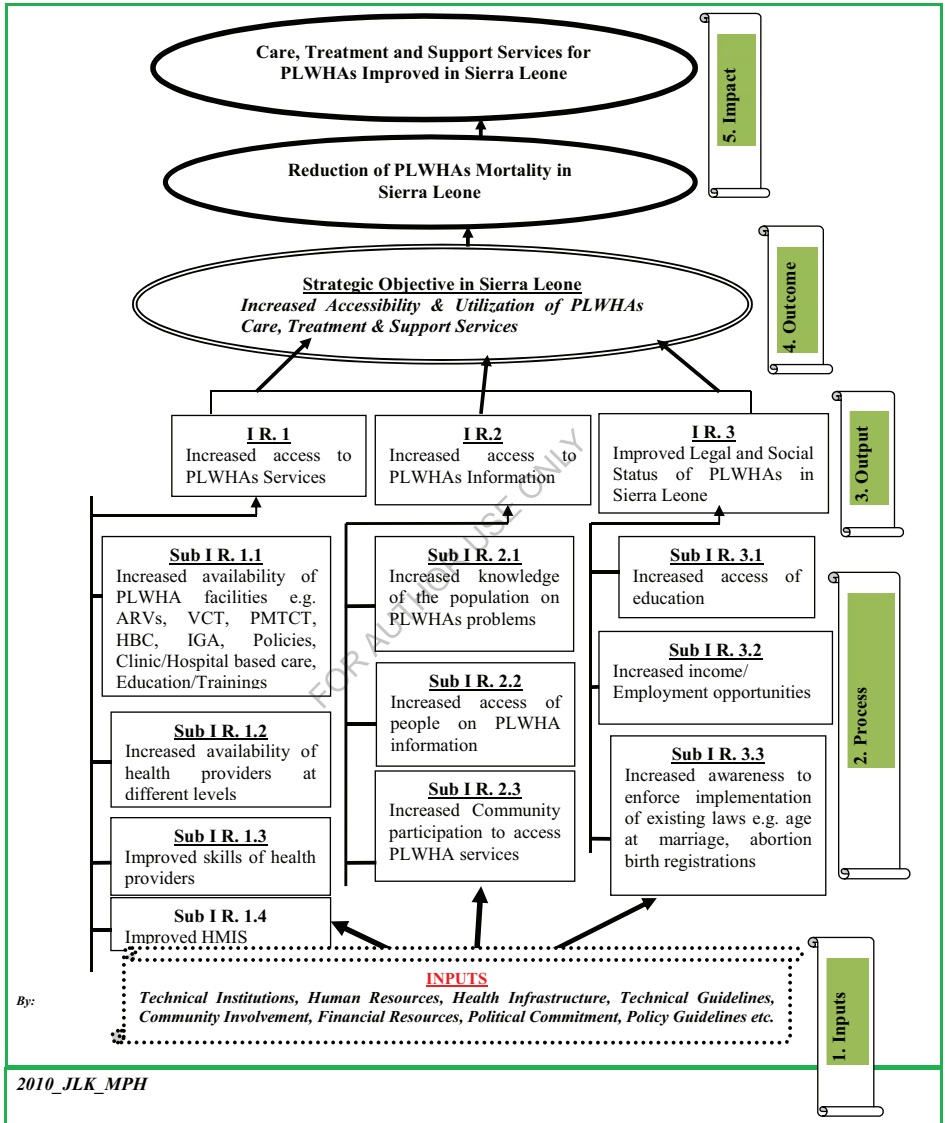

Table 2.6 Indicators for Evaluation of HIV and AIDS CTS Programmes

Objective	Indicator	Source of data	Frequency of data collection	Responsibility
Purpose Level				
Increase in the utilization of Care and Support services	Percentage of PLWHAs using clinic – or hospital-based care	DHS, Sero-prevalence surveys	2-5 years	NAS, MOHS, SSL
Output Level				
Increased access of quality Care and Support services	**1.** Percentage of PLWHAs having access to Care and Support services within 2 hours of travel distance **2.** Percentage of PLWHAs visited by health personnel	DHS, Sero-prevalence surveys	2-5 years	NAS, MOHS, SSL
Increased access of Care and Support Information	**1.** Percentage of PLWHAs who have exposure to mass media information **2.** Percentage of PLWHAs who heard information on Care and Support interventions from radio program	DHS	Every 5 years	NAS, MOHS, SSL

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2.8 Conceptual framework of study

Objective of this study was to evaluate, assess and direct or recommend policies and services of the care, treatment and support program implementation during the period of 2006 to 2010 National HIV/AIDS Strategic plan in Sierra Leone. Government strategies during the 2006 to 2010 strategic plan were to increase the availability, accessibility and utilization of HIV/AIDS care, treatment and support interventions / services through the establishment of national secretariat and health facilities and other development partners interventions, to improve the skills of health workers, to intensify the care, treatment and support activities through the provision of HBC, VCCT, PMTCT, ART, Condoms, treatment of OIs & STIs outreach clinics and home visits. Although different interventions were done during the plan period, yet due to the lack of data, only

VCCT by health worker was taken as the proxy measure of availability of care, treatment and support services. Time travel to the nearest facility could not be used because of the higher percentage of missing cases.

One of the most important components of program intervention in Sierra is to create awareness through IEC on mass media. The information about whether PLWHAs heard radio program on HIV/AIDS and heard HIV/AIDS information (ART, Condoms, etc) on mass media were taken as the proxy variables for the access to the HIV/AIDS information.

As one of the objective of care, treatment and support program was to raise the status of PLWHAs. Various activities were concluded with the help of inter sectoral collaboration amongst ministries, departments and agencies. Among the activities were income generation programs, support to PLWHAs in technical and vocational trainings etc. Even though the concept of PLWHAs status is broad and can be measured from several dimensions. For the purpose of this study, employment status of PLWHAs was taken as a proxy variable to measure the status of PLWHAs as shown in the result framework. PLWHAs demand of the services affects the utilization of care, treatment and support services and different socio economic factors such as household economic status, place of residence and education, etc.

This impact of program intervention cannot be predicted without the consideration of these factors. Based on the literatures reviewed and SLDHS data set, five control variables were used which are age, marital status, education, gender, and education.

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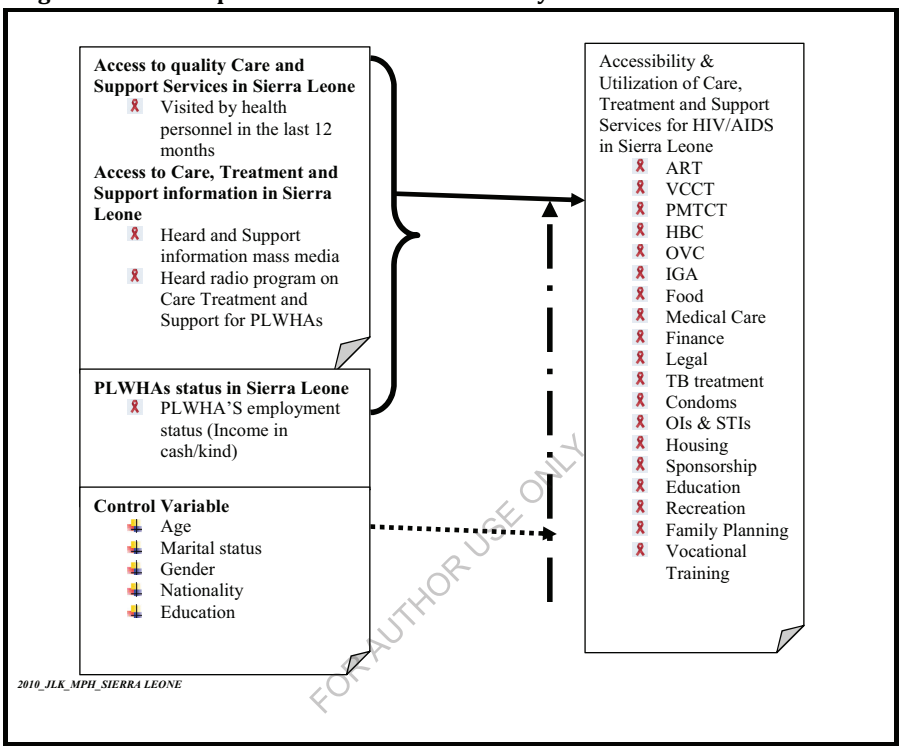
Figure 2.5 Conceptual framework for the study



CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1 Sources of Data

The research was carried out in the western area of Sierra Leone, in the rural and peri-urban areas of the capital city of Freetown. Primary data was collected through discussions with policy makers, dissertation supervisor, lecturers and colleagues who are working in the related field of care, treatment and support for people living with HIV/AIDS. The data sources also included information gathered from conferences and workshops attended by the researcher. Secondary data from the clinics or service delivery points, policy documents from the national AIDS Secretariat and the ministry of health and sanitation, research documents and publications on HIV/AIDS care, treatment and support services programmes that aid PLWHAs in care, treatment and support interventions in the country and the study area in particular; reports from consultancies and the internet was also utilized extensively.

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For the research, any person living with HIV/AIDS under the care, treatment and support program of the Methodist Church Sierra Leone in the western area that came to the service provision point / clinic rendering the various services between 8.30am and 4pm on the Fridays, and who gave consent to be interviewed were included in the study. Demographic and medical records of people living with HIV/AIDS who utilized the service delivery points / clinic from 02 April 2010 to 31 May 2010 were examined. Monthly statistics of utilization of different services were also reviewed and captured.

3.2 Study design and sample population

The research employed a cross-sectional, descriptive research design where questionnaires were administered to assess accessibility and utilisation of services, and a document review of both the

non-governmental organizations records (register book or monthly statistics) were checked to investigate utilization and accessibility trends of services.

A probability sampling method (a simple random sampling) technique was used for sampling. In this technique, all persons attending the service provision point / clinic had an equal chance of being selected for the study. Using the register of the people who registered to utilize the service provision point / clinic that day, 10 were sampled at the provision point on a weekly basis on Fridays. On those Fridays, the service provision point saw (±) 50 people living with HIV/AIDS per day on average and 10 of them (20%) were selected, and questionnaires administered. The Fishbowl technique was used (placing numbers in a container and drawing out the numbers one at a time). The following steps were followed:

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- A number was written from the sampling list on a separate slip of paper.
- The slips were put into the container/fishbowl.
- The slip was drawn, the number noted, the slip replaced, the bowl shaken and the second one selected and so on until the required number (10) was reached.

The study target a population of about 100 PLWHAs comprising children, women and men with ages ranging from under five years to above fifty five years.

3.3 Study setting

The study was conducted at the Methodist Church Sierra Leone services delivery points / clinics rendering the care, treatment and support services in greater Freetown area. The services are open throughout the operational days and provide almost all care, treatment and support services to people living with HIV/AIDS.

3.4 Area of the research

Sierra Leone is situated in the West Coast of Africa. It is divided administratively into three provinces and the western area. Each of the provinces is sub-divided into districts, districts into chiefdoms, chiefdoms into sections and sections into villages. The study was conducted in the western area of Sierra Leone, which is divided into rural and urban areas. The research area covered mainly the rural and peri-urban communities of Kissy, Willington, Calaba town, and Allen town and beyond, as well as some parts of the cline town community.

Map Republic of Sierra Leone
District

3.5 Data collection

Data collection was accomplished according to the schedule. The majority of the interviews took place in the mornings. Typical, ten questionnaires were finished each day of the interview on Fridays. On average, it took 40 minutes to complete an interview.

One major method of data collection was used. Questionnaire was administered for collection of quantitative data. The questionnaire was divided into two sections: the demographic data and the

service delivery / clinic information data focusing on accessibility and utilization with satisfaction of services rendered to PLWHAs.

Administered questionnaires were given randomly to people who utilized the service provision point / clinic that day. Secondly, a review of the facilities records and data plus the organisations records as well were used to source information regarding accessibility and utilization of services at those service delivery points / clinics.

The register book and monthly statistics records were also assessed to obtain or determine the information on: staff component, utilization trends by Age i.e. total number of people < 5yrs, 16–25yrs, 26-35yrs, 36-45yrs & >45yrs for instance, number of patients seen by nurses per day, number of patients seen by CHOs per day, number of patients seen by Doctors per day, Total number of patients seen at the service provision point / clinic for that month etc.

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3.6 Data analysis

Completed questionnaires were checked in the field by the researcher at the end of each day from the clinics or service delivery points and edited them. If errors or incomplete information were found appropriate corrections were made thereof. The data was entered in the CSPro software and exported to the SPSS version 18 programme for analysis and production of statistical tables, which were further transferred to excel spreadsheet for the production of charts, graphs, and histograms. However, the process proved very challenging for the entire research team, but we confronted it all. Cleaning and analysis of the data were the sole responsibility of the author. After verification and cleaning of the database, the data was then analyzed using SPSS and the micro soft excel spreadsheet. Outputs were presented mostly in frequency tables and cross-tabulations based on the indicators. The analysis will be purely descriptive analytical case making use of tabular,

qualitative, quantitative, inferential and categorical methods to give vivid information of the variable under investigation.

3.7 Reliability and validity of study

A pilot study (small-scale version run of the major study) was done to test the instrument. By doing a pilot study, feasibility of the study was investigated (the validity of the measuring tools and the acceptability of the study to the study population) so that any problems could be identified early and information may be obtained for improvement.

The findings of the pilot study helped the researcher to remove questions that were vague.

3.8 Limitation of the study

Because of time and financial constraints, it was not possible for the researcher to conduct research on all the care, treatment and support funded projects / programs in the western area. The researcher selected the Methodist Church Sierra Leone program because they provide most of the care, treatment and support services to people living with HIV/AIDS in their operational areas.

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3.9 Ethical considerations

This study touched on some ethical issues and recognized that HIV/AIDS is a sensitive topic given the stigma attached to the disease. It was expected that many people living with HIV/AIDS may not be willing to come out and discuss their situation openly. The concern was that the study involved discussions and interviews on care, treatment and support of people living with HIV/AIDS without offering immediate help for relief of symptoms.

In view of the concerns the researcher ensured that participation was voluntary and only with informed consent of the individual participants.

Participants were given information to enable them to make decisions to either participate in the study or not. The benefit of taking part in the study was explained in the informed consent

document, i.e. to improve the quality of care, treatment and support services for PLWHAs in the future. Participants were assured that their identity would remain anonymous and that all the discussions would be held confidential.

Participants were expected to have read or read to the consent by the researcher and understood the content and the purpose of the study before participating. Consent forms and questionnaires were in English. Also service provision /clinic records were reviewed. Sources of information were acknowledged and official permission to use service provision / clinics was obtained. All records were kept confidential and used solely for the purpose of the study. Confidentiality for participants was ensured through the use of numbers for identification as well as through adherence to venues of each participant's choice for discussion and interviews.

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3.10 Conclusion

A quantitative and descriptive research approach was adopted by using a questionnaire to elicit information from people living with HIV/AIDS who utilized the Methodist church Sierra Leone's care, treatment and support program in the western area. The aim of the study was to investigate whether the care, treatment and support services are accessible to and utilized by PLWHAs in the Methodist Church Sierra Leone program. Findings of this study would be forwarded to the National HIV/AIDS Secretariat for improvement of the services.

CHAPTER FOUR

4. DATA ANALYSIS AND INTERPRETATION - RESEARCH FINDINGS

4.1 Data analysis and interpretation

This chapter is preferably a section that is along the lines of the objectives of the research. It basically comprises of two parts: the results and discussions. The first part presents the results of the study in relation to the proportions / hypothesis. It highlights the objectives of the study, the way the variables were measured and presents the results to determine the accessibility and utilization of the services rendered to people living with HIV and AIDS, their families, communities and the nation as a whole, in words, figures, units in a frequency distribution table and bar charts etc. It also relates the results to the proportion or hypothesis for consistency.

As indicated, data collected from the in-depth interviews was analyzed with the use of PASW Version-18 for Macs (also called SPSS for Windows) and the results of the research were presented using the SPSS Version-18, the CSPro and the Excel spreadsheet. Cross tabulation is also done to determine the relationship between the predictor variables and the response.

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4.2 Socio-Demographic information / characteristics

4.2.1 Participants characteristics

Out of the 97 participants that responded to the research, 83 (85.6%) a large proportion directly responded for themselves (self-respondents) parents/guardians who responded on behalf of children below 5 years of age and for those above who were not able to respond for themselves were 14 of the 97 (14.4%) in the study population. The respondents were asked to indicate the category of participation in the interview, by either self or parent/guardian. The responses were analyzed and tabulated as shown in table 4.1 in the next page.

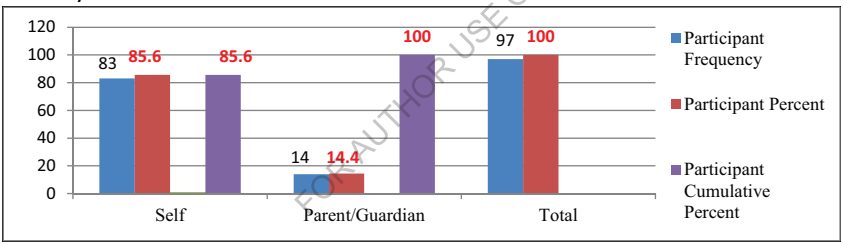
Table 4.1: Frequency distribution of Participants by Self and Parent/Guardian

Participant	Frequency	Percentage (N=97)	Valid Percent	Cumulative Percent
Self	83	85.6	85.6	85.6
Parent/Guardian	14	14.4	14.4	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Table 4.1 is translated into the histogram below by levels of frequency distribution, indicating that, self-respondents (83) were slightly six times (85.6%) more represented in the study population than the parent/guardian (14) who responded on behalf of others (14.4%).

Figure 4.1: Frequency distribution of Participants by Self and Parent/Guardian



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Source: Author's data_2010

4.2.2: Age Distribution of participants

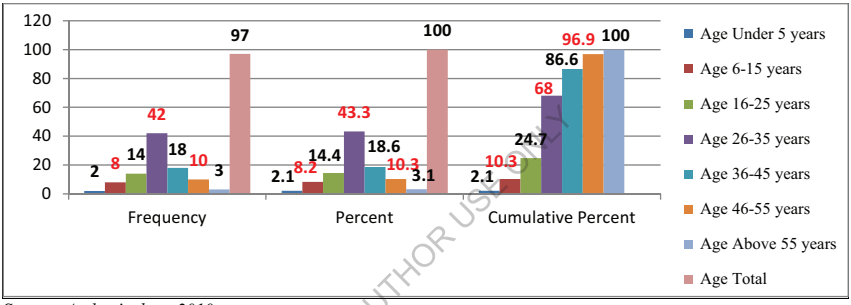
The age distribution of the respondents is presented in Table 4.2. The tabulation suggests that the 26-35 year age group was the highest in the sample population with 43.3%, followed by the 36-45 years age group (18.6%) and 10 participants (10.3%) ranged from ages of 46-55 years. The table below shows age distribution in percentages of which 6-15years old age group accounting for 8.2%. The adolescents 16-25 years old accounted for 14.4% of the sample. The two extreme age groups were the least represented in the study, i.e. under 5 years old and above 55 years, with 2.1% and 3.1% respectively.

Table 4.2: Frequency distribution by age of participants

Age	Frequency	Percent	Valid Percent	Cumulative Percent
Under 5 years	2	2.1	2.1	2.1
6-15 years	8	8.2	8.2	10.3
16-25 years	14	14.4	14.4	24.7
26-35 years	42	43.3	43.3	68.0
36-45 years	18	18.6	18.6	86.6
46-55 years	10	10.3	10.3	96.9
Above 55 years	3	3.1	3.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.1.1: Illustration of the frequent distributions of participants by age



Source: Author's data_2010

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Figure 4.1.1 above, illustrates the percentage distribution of respondents by age groups, and number of participants shows that the productive age group or labor force, ages ranging from 16 - 55 years constitute 94.8% of PLWHAs, this indicates very serious socio-economic burden on families, communities and the nation as a whole.

4.2.3: Gender

The research findings disaggregated participants by gender and revealed the following, 41 (42.3%) were males and 56 (57.7%) were females, Out of the 97 respondents, only 83 (85.6%) reported as self-respondents of which 37 (38.1%) were males and 46 (47.4%) females, Parents/guardians who responded on behalf of children below 5 years of age and for those above who were not able to

respond for themselves were 14 (14.4%), of which 4 (4.1%) were male and 10 (10.3%) female. Overall, indicating that more females 57.7% participated in the research than males 42.3%.

Table 4.3: Frequency distribution by gender of participants

Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Male	41	42.3	42.3	42.3
Female	56	57.7	57.7	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.2.4 Religion

The study also sought to find out whether there is any relationship between the PLWHAs and the religion the practice (Tables 4.3 & 4.4) The respondents were asked to state their religion, results revealed that there were more Muslims N=53 (54.6%) than Christians N=44 (45.4%) who were lining with HIV/AIDS in the research population. On cross tabulation, data also revealed that, of the 57.7% females, 42.3% were Muslims and 15.5% Christians, and that of the 42.3% males only 12.4% were Muslims and 29.9% Christians.

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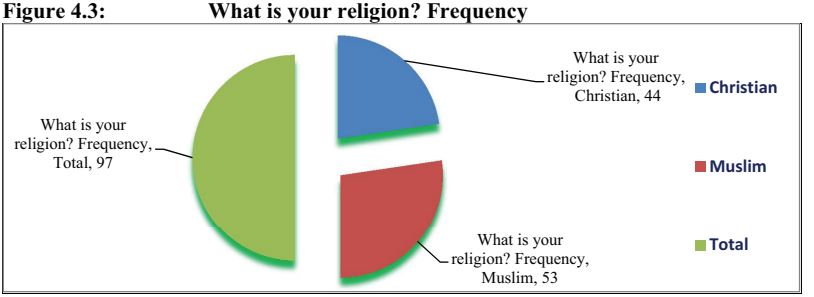
Table 4.4: What is your religion? Frequency

What is your religion?	Frequency	Percent	Valid Percent	Cumulative Percent
Christian	44	45.4	45.4	45.4
Muslim	53	54.6	54.6	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.3: What is your religion? Frequency



Source: Author's data_2010

Table 4.4.1 Gender - What is your religion? Cross-tabulation

			What is your religion?		
			Christian	Muslim	Total
Gender	Male	Count	29	12	41
		% Gender	70.7%	29.3%	100.0%
		% What is your religion?	65.9%	22.6%	42.3%
		% of Total	29.9%	12.4%	42.3%
	Female	Count	15	41	56
		% Gender	26.8%	73.2%	100.0%
		% What is your religion?	34.1%	77.4%	57.7%
		% of Total	15.5%	42.3%	57.7%
Total		Count	44	53	97
		% Gender	45.4%	54.6%	100.0%
		% What is your religion?	100.0%	100.0%	100.0%
		% of Total	45.4%	54.6%	100.0%

Source: Author's data_2010

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4.2.5 Sierra Leone citizenship

With the global village in which we all live and with migration and immigration on the increase, participants were asked about their nationality / citizenship. Results indicated in Table 4.5 below revealed that of the 97 respondents, 90 (92.8%) were Sierra Leone. Cross tabulation of citizenship and gender of Sierra Leoneans, (90) who participated in the study, 50 were females (55.6%) and 40 males (44.4%). Only 7 (7.2%) said they were not Sierra Leonean citizens, 6 were females and 1 male.

Table 4.5: Are you a Sierra Leonean?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	90	92.8	92.8	92.8
No	7	7.2	7.2	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.2.6 Highest level of School Attended by participants

The data suggest huge gender disparities in education attainment (Table 4.6). For instance, 66.7% of all males had higher education compared to 33.3% of females. In addition, only 12.5% of males had vocational training compared to 87.5% of females. The level of no school attendance is N=21 (21.6%) (Figure 4.2.5) indicating that they had never attended school, as against N=76 (78%) who had attended at some level. That 29.9% had at least attended a primary school, 13.4% and 17.5% had get to junior and senior secondary levels respectively.

Table 4.6: What is the highest level of school you attended, if at all?

			What is the highest level of school you attended, if at all								Total
			Never attended school	Primary	Tech-Voc	Vocational	Junior Secondary	Senior Secondary	Higher	other	
Gender	Male	Count	7	12	0	1	6	11	2	2	41
		% Gender	17.1%	29.3%	.0%	2.4%	14.6%	26.8%	4.9%	4.9%	100%
		% Highest level of school you attended, if at all	33.3%	41.4%	.0%	12.5%	46.2%	64.7%	66.7%	66.7%	42.3%
		% of Total	7.2%	12.4%	.0%	1.0%	6.2%	11.3%	2.1%	2.1%	42.3%
	Female	Count	14	17	3	7	7	6	1	1	56
		%: Gender	25.0%	30.4%	5.4%	12.5%	12.5%	10.7%	1.8%	1.8%	100%
		% Highest level of school you attended, if at all	66.7%	58.6%	100%	87.5%	53.8%	35.3%	33.3%	33.3%	57.7%
		% of Total	14.4%	17.5%	3.1%	7.2%	7.2%	6.2%	1.0%	1.0%	57.7%
Total		Count	21	29	3	8	13	17	3	3	97
		%: Gender	21.6%	29.9%	3.1%	8.2%	13.4%	17.5%	3.1%	3.1%	100%
		% Highest level of school you attended, if at all	100%	100.0%	100%	100%	100%	100%	100%	100%	100%
		% of Total	21.6%	29.9%	3.1%	8.2%	13.4%	17.5%	3.1%	3.1%	100%

Source: Author's data_2010

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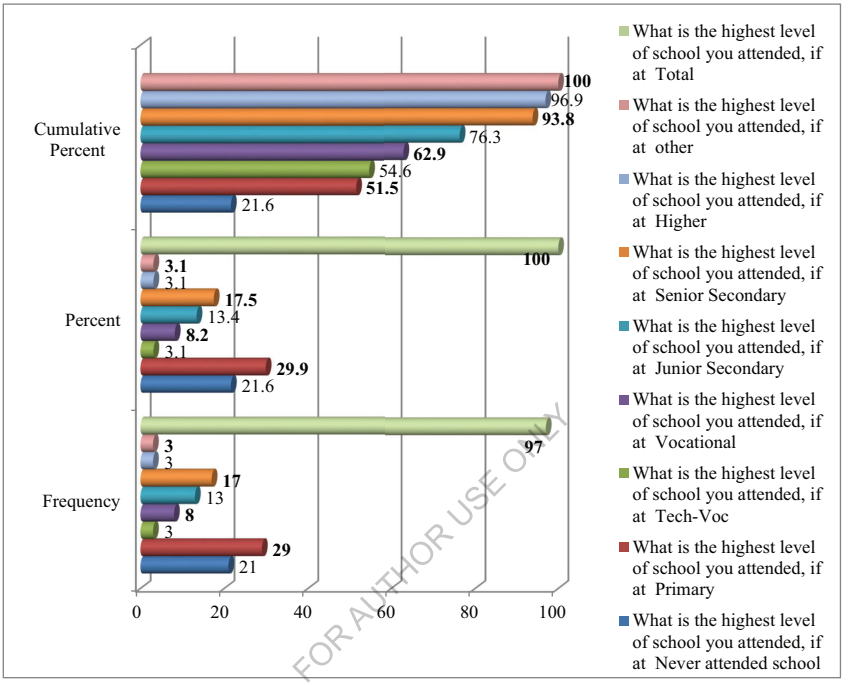
Figure 4.2.5: Levels of School Attended by participants

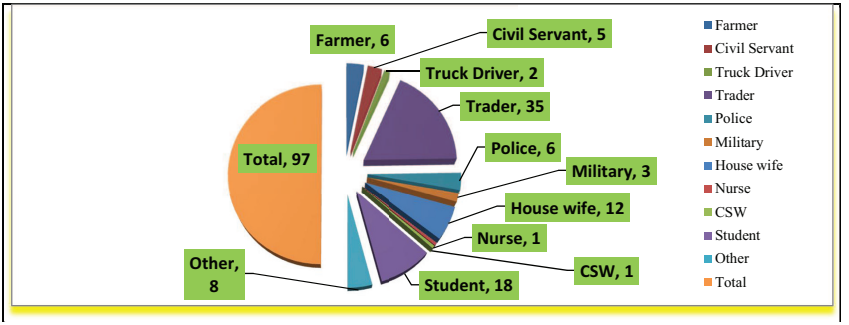


Source: Author's data_2010

4.2.7 Main occupation of participants

The data suggests that traders are more likely to be affected 35 (36.1%) than those from all other occupational categories (Figure 4.2.6).This is followed by students 18 (18.6%) and house wife's 12 (12.4%). Interestingly, as a result of their professions, CSWs and Nurses only reported 1% each. After cross tabulation, traders who reported highest had 62.9% females and 34.3% were males.

Figure 4.2.6: Frequency of main occupation?



Source: Author's data_2010

4.2.8 Marital Status

Table 4.7 presents the marital status of the PLWHAs who participated in the research, cross tabulated by gender (Table 4.7). The table shows that 49.5% were married, of which, 20 (48.8%) were males and 50.0% were females, compared to 5.2% divorced. A relatively higher percentage of singled reported for the research (36.1%), compared to separated (9.3%). This probably implies that these participants may have lost a spouse to the scourge.

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Table 4.7: Gender * what is your marital status? Cross-tabulation

			What is your marital status?				
			Single	Married	Divorced	Separated	Total
Gender	Male	Count	16	20	3	2	41
		% Gender	39.0%	48.8%	7.3%	4.9%	100.0%
		% Marital status?	45.7%	41.7%	60.0%	22.2%	42.3%
		% of Total	16.5%	20.6%	3.1%	2.1%	42.3%
	Female	Count	19	28	2	7	56
		% Gender	33.9%	50.0%	3.6%	12.5%	100.0%
		% Marital status?	54.3%	58.3%	40.0%	77.8%	57.7%
		% of Total	19.6%	28.9%	2.1%	7.2%	57.7%
Total		Count	35	48	5	9	97
		% Gender	36.1%	49.5%	5.2%	9.3%	100.0%
		% Marital status?	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	36.1%	49.5%	5.2%	9.3%	100.0%

Source: Author's data_2010

Table 4.7.1: Marital status

	Frequency	Percent	Valid Percent	Cumulative Percent
Single	35	36.1	36.1	36.1
Married	48	49.5	49.5	85.6
Divorced	5	5.2	5.2	90.7
Separated	9	9.3	9.3	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.2.9 Cause of Infection

The cause of HIV infection is illustrated in figure 4.2.7 below. The figure suggests that most participants 72 (74.2%) established cause of infection as unknown. This was followed by 11 (11.3%) that were infected through blood transfusion, while 6.2% contracted the virus through commercial sex workers. The category who responded for themselves reported equal percentages by gender for their causes of infection at 33.3% each on cross-tabulation.

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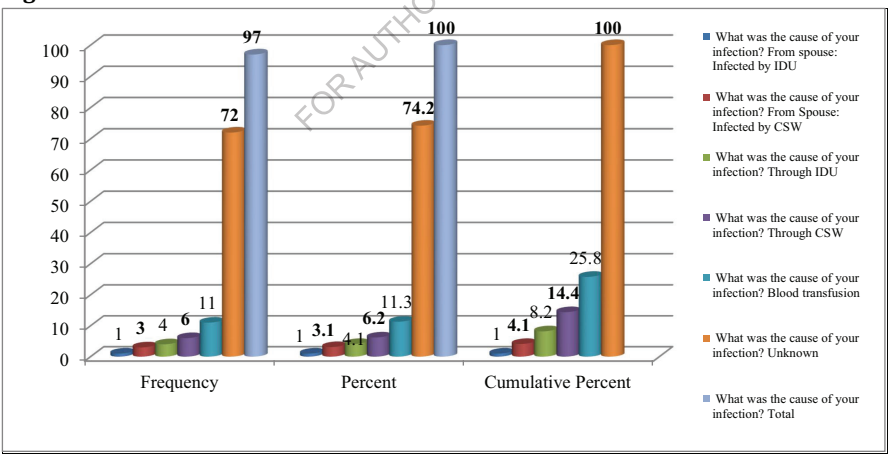
Figure 4.2.7: Cause of Infection



Source: Author's data_2010

4.2.10 On ART treatment

ARVs and other services to PLWHAs are supposed to be free, based on the national policy (revised 2007) in all health facilities. The research findings revealed that 89 of the 97 respondents reported been on ARVs, representing 91.8% of the overall, and of which, 47.2% were females and 39.3% males who responded for themselves.

Table 4.9: Are you on ART Treatment?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	89	91.8	91.8	91.8
No	8	8.2	8.2	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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4.2.11 Distance travelled to the service delivery point / clinic:

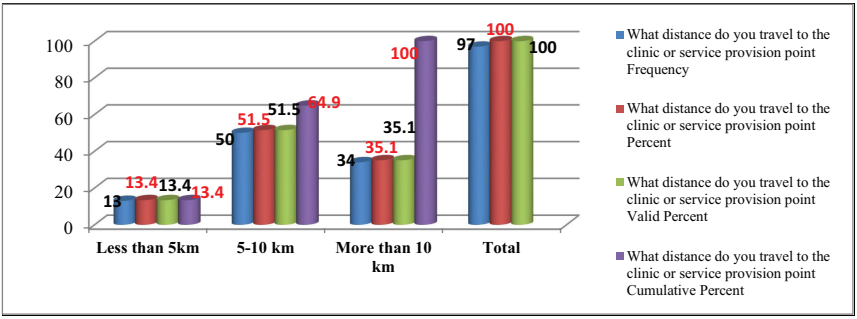
Table 4.10 presents the distance travelled to the service delivery point or clinics of the PLWHAs who participated in the research. The table shows that a significant proportion of the participants 50 (51.5%) traveled 5-10 km to the clinic, of which 29 were females, 21 males. This finding is true irrespective of gender. Participants who reported to have traveled less than 5 km were just 13 (15.4%), of which 7 were females, 6 males. Those who traveled above 10 km were 34 (35.1%) of which 20 were females, 14 males. This result is not indicative of good accessibility as distance travelled by the respondents to the service delivery point or clinics is one of the key parameters used to assess accessibility considering standards set for accessibility to be within the range of less than 5 km to a facility.

Table 4.10: Distance travelled to the service delivery point / clinic

	Frequency	Percent	Valid Percent	Cumulative Percent
Less than 5km	13	13.4	13.4	13.4
5-10 km	50	51.5	51.5	64.9
More than 10 km	34	35.1	35.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.8: Distance travelled to the service delivery point / clinic



Source: Author's data_2010

4.2.12 Distribution of traveling time

Figure 2.4.8 shows that 20 (20.6%) of the respondents reported to have traveled for 30 minutes or less to the service delivery point / clinic. Participants who traveled for 30 minutes-1 hour were 48 (49.5%) and those who traveled longer than an hour were 29 (29.9%). It should be noted that this composite indicator for effective accessibility is not on track in delivering services to PLWHAs in terms of traveling timing. Against the backdrop of standards set for accessibility, traveling time to the facility should be 30 minutes or less.

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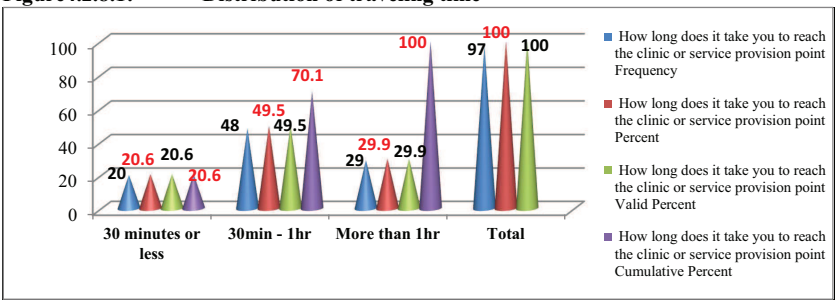
Figure4.2.8.1: Distribution of traveling time



Source: Author's data_2010

4.2.13 Means of transportation

Participants were investigated to measure the means of transport used to reach the service delivery points / clinics. Participant's responses are analyzed in the table below by type of transportation used.

Table 4.12: Means of transportation

Means of transport				
	Frequency	Percent	Valid Percent	Cumulative Percent
Walk	25	25.8	25.8	25.8
Taxi	38	39.2	39.2	64.9
Bus	30	30.9	30.9	95.9
Okada	2	2.1	2.1	97.9
Own Transport	2	2.1	2.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Table 4.1.2 above shows that most (just over three quarters of the total respondents) of the participants, 38 (39.2%) used taxi as a mode of transportation to go to the service delivery point / clinic. On cross- tabulation of the data by age , 2 respondents (5.3%) were above 45 years of age, 22 (57.9%) were between 26 to 35 years, 7 (18.4%) with an age range of 16 to 25 years, and 4 (10.5%) with age ranges of 36 to 45 years. The second most common means of transport was the Bus which captured 30.9% of the participant's usability of transport.

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Table 4.12.1: Participant * Means of transport Cross-tabulation

			Means of transport					Total
			Walk	Taxi	Bus	Okada	Own T/P	
Partici pant	Self	Count	22	36	22	2	1	83
		% Participant	26.5%	43.4%	26.5%	2.4%	1.2%	100.0%
		% Means of transport	88.0%	94.7%	73.3%	100.0%	50.0%	85.6%
		% of Total	22.7%	37.1%	22.7%	2.1%	1.0%	85.6%
	Parent/ Guardian	Count	3	2	8	0	1	14
		% Participant	21.4%	14.3%	57.1%	.0%	7.1%	100.0%
		% Means of transport	12.0%	5.3%	26.7%	.0%	50.0%	14.4%
		% of Total	3.1%	2.1%	8.2%	.0%	1.0%	14.4%
Total		Count	25	38	30	2	2	97
		% Participant	25.8%	39.2%	30.9%	2.1%	2.1%	100.0%
		% Means of transport	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	25.8%	39.2%	30.9%	2.1%	2.1%	100.0%

Source: Author's data_2010

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4.3 Are you or child infected with HIV?

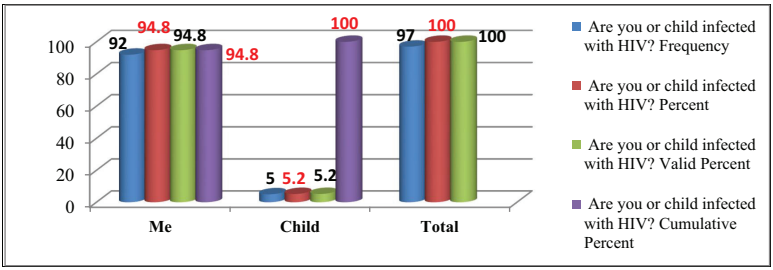
Participants were asked if they or child were infected with the HIV. Table 4.13 shows the analyzed results from the respondents. 92 (94.8%) reported been infected and 5 (5.2%) were children infected with HIV who participated in the research.

Table 4.13: Are you or child infected with HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Me	92	94.8	94.8	94.8
Child	5	5.2	5.2	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure4.2.9: Are you or child infected with HIV?



Source: Author's data_2010

4.4 Service utilization and satisfaction at provision points or clinics by PLWHAs:

Care, treat and support services provision to People Living with HIV/AIDS is a critical intervention to lessen the burden on families, communities and nations, in this regards, respondents/ PLWHAs who participated in the research, were asked to state the reasons for visiting they service provision points or clinics as well as to gauge their levels of utilization and satisfaction of the under-mentioned thematic services rendered to them using this pre-defined scale as: *very dissatisfied; dissatisfied; neither satisfied nor dissatisfied; satisfied and very satisfied*

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Below are 19 thematic interventions deemed required to address care, treatment and support services for PLWHAs, against these backdrops, respondents were investigated to measure their reasons and levels of both utilization and satisfaction of the services mentioned below:

4.4.1 Finance:

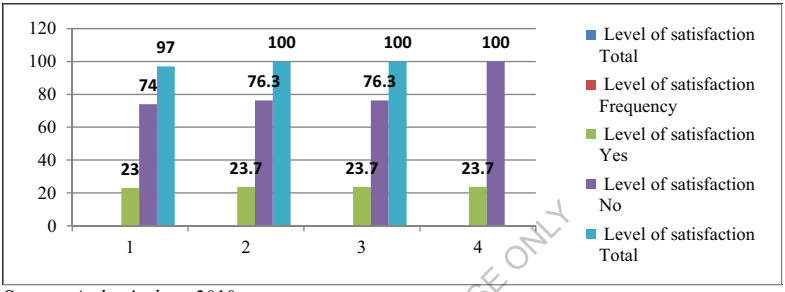
Of the 97 respondents, 23 PLWHAs (23.7%) indicated reasons for visiting either the service provision points or clinics for financial assistance or support. With regards to the levels of utilization and satisfaction on financial arrangements, the following were the findings; very dissatisfied-2, dissatisfied-6, satisfied-3, and indicating that neither satisfied nor dissatisfied represented 12 respondents.

Table: 4.14 Finance

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	23	23.7	23.7	23.7
No	74	76.3	76.3	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure4.2.10: Finance - Levels of utilization and satisfaction



Source: Author's data_2010

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Table: 4.14.1: Participant * Level of satisfaction Cross-tabulation

Finance			Level of satisfaction				Total
			Very Dissatisfied	Dissatisfied	Not for Service	Satisfied	
Participant	Self	Count	2	5	75	1	83
		% Participant	2.4%	6.0%	90.4%	1.2%	100.0%
		% Level of satisfaction	100.0%	83.3%	87.2%	33.3%	85.6%
		% of Total	2.1%	5.2%	77.3%	1.0%	85.6%
	Parent/ Guardian	Count	0	1	11	2	14
		% Participant	.0%	7.1%	78.6%	14.3%	100.0%
		% Level of satisfaction	.0%	16.7%	12.8%	66.7%	14.4%
		% of Total	.0%	1.0%	11.3%	2.1%	14.4%
Total		Count	2	6	86	3	97
		% Participant	2.1%	6.2%	88.7%	3.1%	100.0%
		% Level of satisfaction	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	2.1%	6.2%	88.7%	3.1%	100.0%

Source: Author's data_2010

4.4.2 Food and Nutrition

Of the 97 respondents, 55 PLWHAs indicated reasons for visiting either the service provision points or clinics for food and nutritional assistance or support. With regards to the levels of utilization and satisfaction on food and nutritional arrangements, the following were the findings; dissatisfied-21, satisfied-24, and indicating that neither satisfied nor dissatisfied represented 10 respondents.

Table 4.15: Food and Nutrition

Food	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	55	56.7	56.7	56.7
No Services	42	43.3	43.3	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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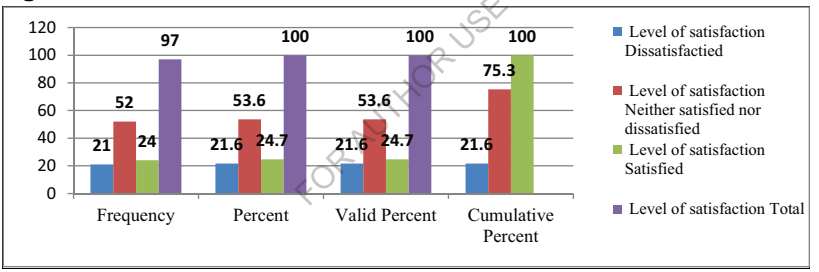
Figure 4.2.11: Food and Nutrition - Levels of utilization and satisfaction



Source: Author's data_2010

4.4.3 Medical Services:

Table 4.16 below and its cross tabulated data indicate that of the 97 respondents, 31 indicated reasons for visiting either the service provision points or clinics for medical services or support. With regards to the levels of utilization and satisfaction on medical services arrangements, the following were the findings; very dissatisfied-1, dissatisfied-2, satisfied-22, and indicating that neither satisfied nor dissatisfied represented 6 respondents.

Table 4.16: Medical Services

Medical	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	31	32.0	32.0	32.0
No Services	66	68.0	68.0	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Similarly, the need of PLWHA for affordable, comprehensive and specialized medical services was emphasized. For the health services to be attuned to the needs of PLWHA and AIDS orphans, they needed to include the treatment of opportunistic infections, counseling and psychological support, and home-based nursing and treatment are crucial ingredients of the overall care, treatment and support services interventions.

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4.4.4 VCCT Services

Voluntary counseling and confidential testing (VCCT), which constitutes an important part of the continuum of care and support services was measured, and of the 97 respondents, 7 indicated reasons for visiting either the service provision points or clinics for VCCT services or support. With regards to the levels of utilization and satisfaction on VCCT arrangements by the respondents, the following were the findings; dissatisfied-1 and satisfied-6.

Table 4.17: VCCT Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	7	7.2	7.2	6.2
No Services	90	92.8	92.8	100.0
Total	97	100.0	100.0	

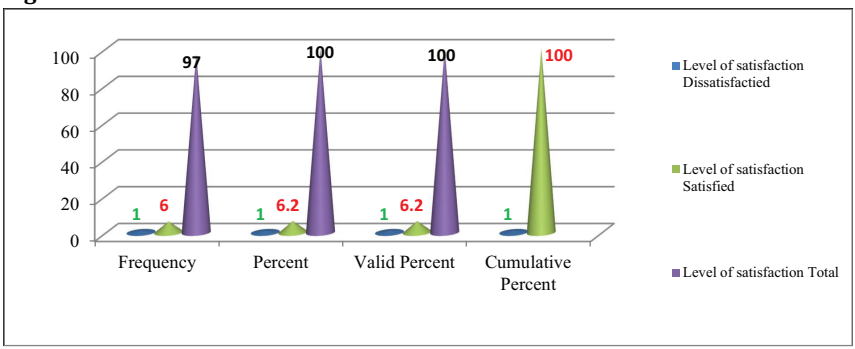
Source: Author's data_2010

Table4.17.1: VCCT - Levels of utilization and satisfaction

	Frequency	Percent	Valid Percent	Cumulative Percent
Dissatisfied	1	1.0	1.0	1.0
Satisfied	6	6.2	6.2	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.12: VCCT- Levels of utilization and satisfaction



Source: Author's data_2010

4.4.5 PMTCT Services

Prevention of Mother-to-Child Transmission also a cornerstone to the care, treatment and support interventions was gauged, and of the 97 respondents, 7 indicated reasons for visiting either the service provision points or clinics for PMTCT services or support. With regards to the levels of utilization and satisfaction on PMTCT arrangements, the following were the findings; that all 7 respondents were satisfied and utilized the services 100%.

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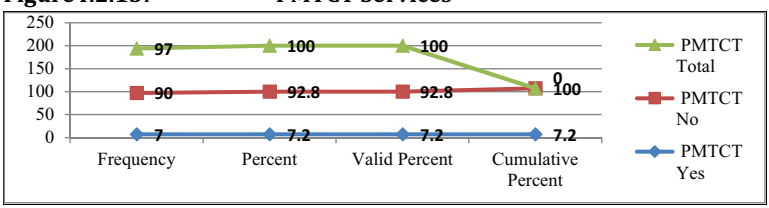
Table 4.18: PMTCT Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	7	7.2	7.2	7.2
No	90	92.8	92.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure4.2.13: PMTCT Services



Source: Author's data_2010

4.4.6 ART Services

Of the 97 respondents, 40 indicated reasons for visiting either the service provision points or clinics for ART services or support. With regards to the levels of utilization and satisfaction on ART arrangements, the following were the findings; dissatisfied-1, satisfied-34, and indicating that neither satisfied nor dissatisfied amounted to 5 respondents.

Table 4.19: ART Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	40	41.2	41.2	41.2
No	57	58.8	58.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Table 4.19.1: ART services- Levels of utilization and satisfaction

ART	Frequency	Percent	Valid Percent	Cumulative Percent
Dissatisfied	1	1.0	1.0	1.0
Not for service	62	63.9	63.9	64.9
Satisfied	34	35.1	35.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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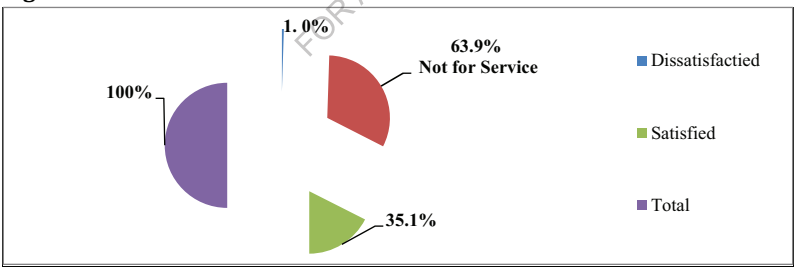
Figure 4.2.13: ART services - Levels of utilization and satisfaction



Source: Author's data_2010

4.4.7 STI Services

Of the 97 respondents, 21 indicated reasons for visiting either the service provision points or clinics for STI services or support. With regards to the levels of satisfaction on STI treatment arrangements, the following were the findings; dissatisfied-4 and satisfied-17.

Table 4.20: STI Services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	21	21.6	21.6	21.6
No	76	78.4	78.4	100.0
Total	97	100.0	100.0	

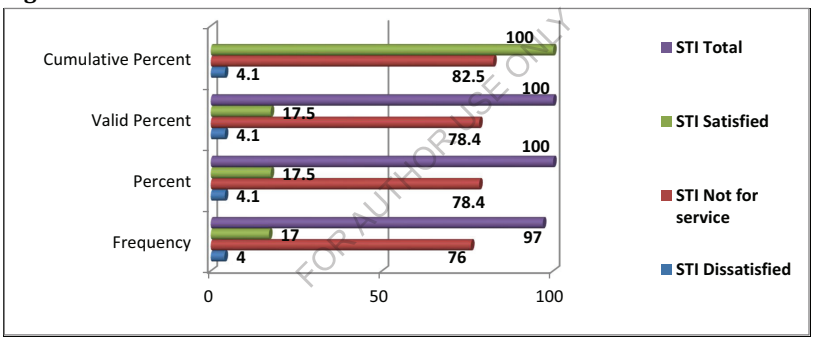
Source: Author's data_2010

Table 4.20.1: STI Services- Levels of utilization and satisfaction

STI	Frequency	Percent	Valid Percent	Cumulative Percent
Dissatisfied	4	4.1	4.1	4.1
Not for service	76	78.4	78.4	82.5
Satisfied	17	17.5	17.5	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure4.2.14: STI Services - Levels of utilization and satisfaction



Source: Author's data_2010

4.4.8 Condom services

Condom promotion is key in the prevention approach to STIs and HIV, and of the 97 respondents, 60 indicated reasons for visiting either the service provision points or clinics for Condom services or support. With regards to the levels of utilization and satisfaction on Condom services arrangements, the following were the findings; very dissatisfied-1, dissatisfied-13, satisfied-36, very satisfied- 3, and indicating that neither satisfied nor dissatisfied amounted to 7 respondents.

Table 4.21: Condom services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	60	61.9	61.9	61.9
No	37	38.1	38.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Table 4.21.1: Condom services - Levels of utilization and satisfaction

Condom	Frequency	Percent	Valid Percent	Cumulative Percent
Very Dissatisfied	1	1.0	1.0	1.0
Dissatisfied	13	13.4	13.4	14.4
Not for service	44	45.4	45.4	59.8
Satisfied	36	37.1	37.1	96.9
Very satisfied	3	3.1	3.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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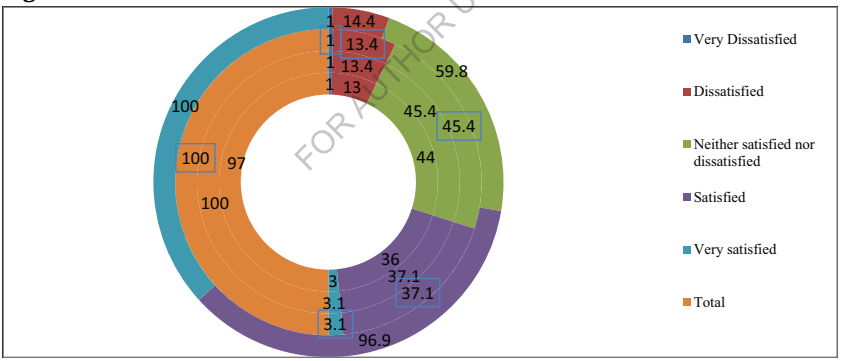
Figure 4.2.15: Condom services - Levels of utilization and satisfaction



Source: Author's data_2010

4.4.9 OVC Services

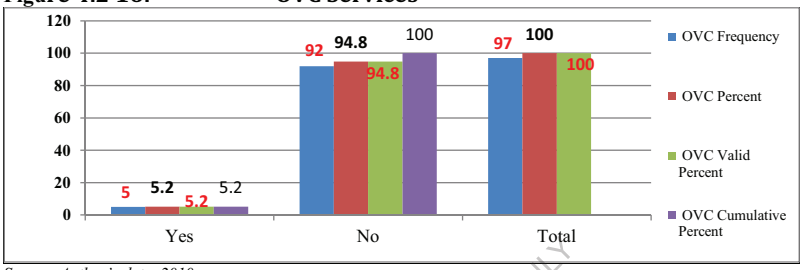
Of the 97 respondents, 5 indicated reasons for visiting either the service provision points or clinics for OVC services assistance or support. With regards to the levels of satisfaction on OVC services arrangements, the following were the findings; dissatisfied-2, and indicating that neither satisfied nor dissatisfied amounted to 3 respondents.

Table 4.22: OVC Services

OVC		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	5	5.2	5.2	5.2
	No	92	94.8	94.8	100.0
	Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2 16: OVC Services



Source: Author's data_2010

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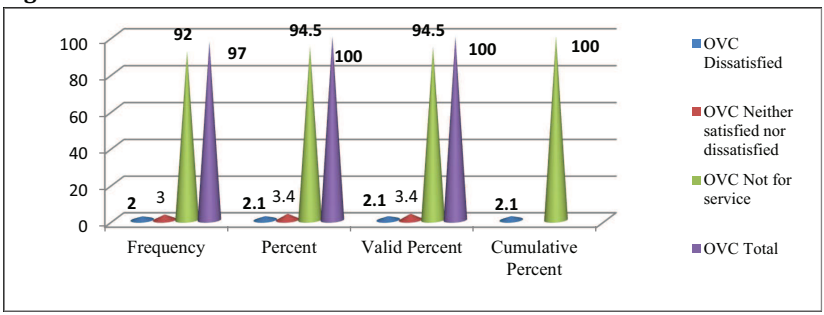
Table 4.22.1: OVC Services- Levels of utilization and satisfaction

OVC	Frequency	Percent	Valid Percent	Cumulative Percent
Dissatisfied	2	2.1	2.1	2.1
Neither satisfied nor dissatisfied	3	3.4	3.4	
Not for service	92	94.5	94.5	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.16.1: OVC services- Levels of utilization and satisfaction



Source: Author's data_2010

4.4.10 TB treatment services

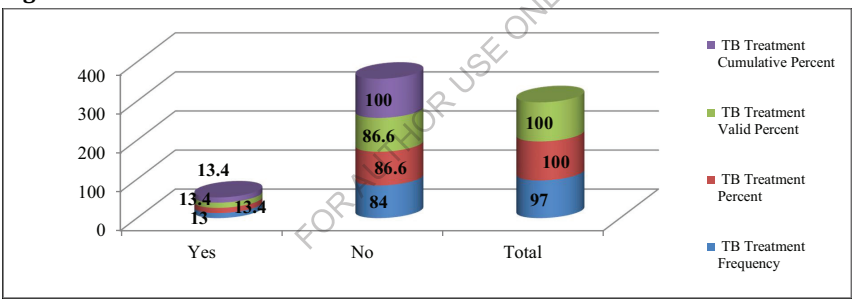
Of the 97 respondents, 13 indicated reasons for visiting either the service provision points or clinics for TB treatment services or support. With regards to the levels of utilization and satisfaction on TB treatment services arrangements, the following were the findings; dissatisfied-10, and satisfied-3.

Table 4.23: TB Treatment

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	13	13.4	13.4	13.4
No	84	86.6	86.6	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2 17: TB Treatment



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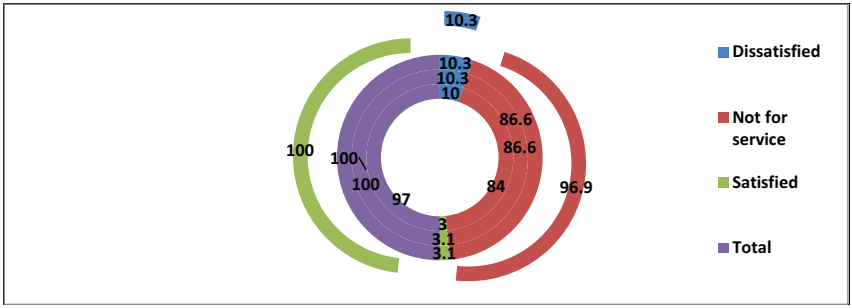
Source: Author's data_2010

Table 4.23.1: TB Treatment- Levels of utilization and satisfaction

TB Treatment	Frequency	Percent	Valid Percent	Cumulative Percent
Dissatisfied	10	10.3	10.3	10.3
Not for service	84	86.6	86.6	96.9
Satisfied	3	3.1	3.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure4.2.18: Levels of utilization and satisfaction



Source: Author's data_2010

4.4.11 Vocational training services

Of the 97 respondents, 6 indicated reasons for visiting either the service provision points or clinics for vocational training assistance or support. With regards to the levels of utilization and satisfaction on vocational training arrangements, the following were the findings; dissatisfied-2, and satisfied-4.

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Table 4.24: Vocational Training

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	6	6.2	6.2	6.2
No	91	93.8	93.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.4.12 Family Planning services

Of the 97 respondents, 20 indicated reasons for visiting either the service provision points or clinics for family planning assistance or support. With regards to the levels of utilization and satisfaction on family planning arrangements, the following were the findings; dissatisfied-6, satisfied-13, and very satisfied-1.

Table 4.25: Family Planning services

Family Planning	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	20	20.6	20.6	20.6
No	77	79.4	79.4	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.4.13 Education services

Of the 97 respondents, 7 indicated reasons for visiting either the service provision points or clinics for education assistance or support. With regards to the levels of utilization and satisfaction on education arrangements, the following were the findings; satisfied-5 and indicating that neither satisfied nor dissatisfied amounted to 2 respondents.

Table 4.26: Education

Education	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	7	7.2	7.2	7.2
No	90	92.8	92.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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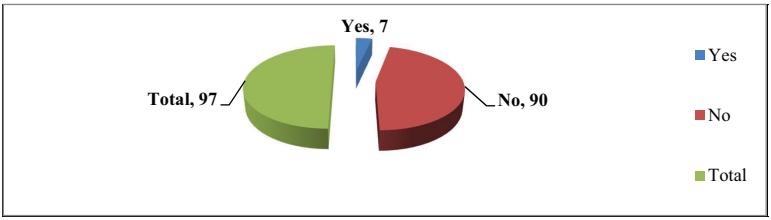
Figure4.2.19: Education Frequency



Source: Author's data_2010

4.4.14 Legal services

PLWHAs had often experienced gross violations of their basic human rights. The injustices faced by PLWHAs range from acts of social discrimination and ostracism to outright denial of property inheritance and transfer rights, and the infection of verbal, physical and sexual forms of abuse.

Protection and implementation of the legal and human rights of PLWHAs and AIDS orphans IS a critical component of the overall care, treatment and support services. Of the 97 respondents, just 2 PLWHAs indicated reasons for visiting either the service provision points or clinics for legal assistance or support. With regards to the levels of utilization and satisfaction on legal arrangements, the following were the findings; all 2 respondents utilized the legal services and were satisfied at that level.

Table 4.27: Legal

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	2	2.1	2.1	2.1
No	95	97.9	97.9	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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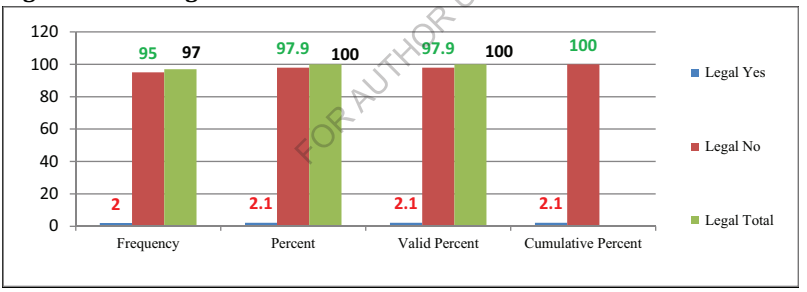
Figure 4.2.20: Legal



Source: Author's data_2010

4.4.15 HBC services

HBC is seen as a major focus area for care, treatment and support interventions and emphasis placed on the advantage from the perspective of both the care providers and recipients. Of the 97 respondents, 8 indicated reasons for visiting either the service provision points or clinics for HBC assistance or support. With regards to the levels of utilization and satisfaction on HBC

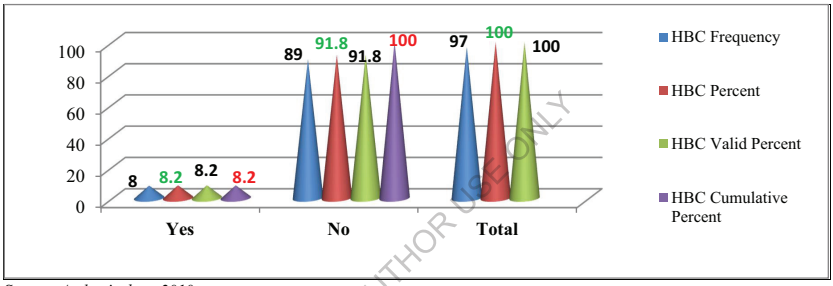
arrangements, the following were the findings; dissatisfied-6, satisfied-1, and indicating that neither satisfied nor dissatisfied represented just 1 respondent.

Table 4.28: HBC services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	8	8.2	8.2	8.2
No	89	91.8	91.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.21: HBC services



Source: Author's data_2010

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4.4.16 Housing services

Of the 97 respondents, 30 indicated reasons for visiting either the service provision points or clinics for housing assistance or support. With regards to the levels of utilization and satisfaction on housing arrangements, the following were the findings; very dissatisfied-1, dissatisfied-26, satisfied-2, and indicating that neither satisfied nor dissatisfied represented 1 respondent.

Table 4.29: Housing

Housing	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	30	30.9	30.9	30.9
No	67	69.1	69.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.4.17 Clothing support

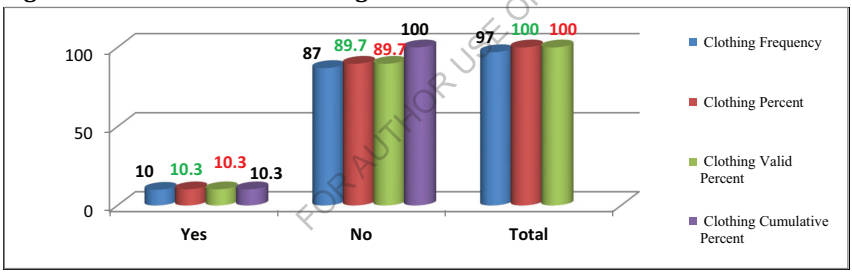
Of the 97 respondents, 10 indicated reasons for visiting either the service provision points or clinics for clothing assistance or support. With regards to the levels of utilization and satisfaction on clothing arrangements, the following were the findings; dissatisfied-1, satisfied-5, and indicating that neither satisfied nor dissatisfied amounted to 4 respondents.

Table 4.30: Clothing

Clothing	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	10	10.3	10.3	10.3
No	87	89.7	89.7	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.22: Clothing



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Source: Author's data_2010

4.4.18 Sponsorship services

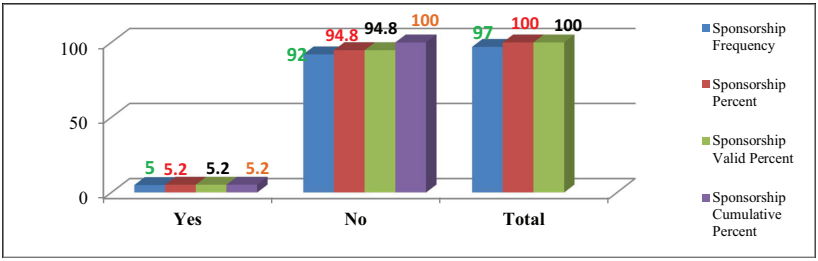
Of the 97 respondents, 5 indicated reasons for visiting either the service provision points or clinics for sponsorship assistance or support. With regards to the levels of utilization and satisfaction on sponsorship arrangements, the following were the findings; very dissatisfied-2, and dissatisfied-3.

Table 4.31: Sponsorship services

Sponsorship	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	5	5.2	5.2	5.2
No	92	94.8	94.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.23: Sponsorship services



Source: Author's data_2010

Table 4.33.1: Sponsorship services - Levels of utilization and satisfaction

Sponsorship	Frequency	Percent	Valid Percent	Cumulative Percent
Very Dissatisfied	2	2.1	2.1	2.1
Dissatisfied	3	3.1	3.1	5.2
Not for service	92	94.8	94.8	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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4.4.19 Recreational services

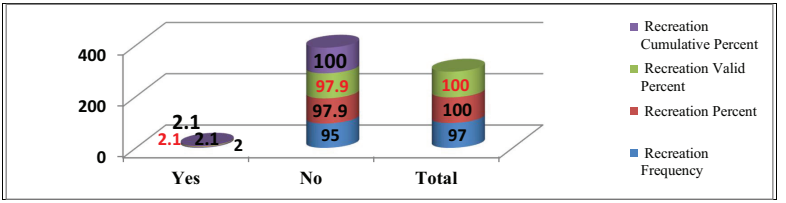
Of the 97 respondents, 2 indicated reasons for visiting either the service provision points or clinics for assistance or support. With regards to the levels of utilization and satisfaction on recreation arrangements, the following were the findings; dissatisfied-1 and indicating that neither satisfied nor dissatisfied amounted to 1 respondent.

Table 4.34: Recreation

Recreation		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	2.1	2.1	2.1
	No	95	97.9	97.9	100.0
	Total	97	100.0	100.0	

Source: Author's data_2010

Figure 4.2.24: Recreation



Source: Author's data_2010

4.5 Do you pay money for any of the above services or intervention before receiving it?

Table 4.35 below shows that 35 (36.1%) of the 97 PLWHAs in the research population paid some money before receiving some form of service or services from either the service delivery points or clinics.

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Table 4.35: Do you pay money for any of the above services before receiving it?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	35	36.1	36.1	36.1
No	62	63.9	63.9	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

PLWHAs were investigated to gauge if the paid moneys for any of the above services rendered to them before receiving them? As indicated in table 4.14 above, it is evident that PLWHAs are paying for the services that are supposed to be rendered free of cost. This reason might probably suggest the high underutilization of some of the services that should contribute to mitigating the burden on those infected and affected by HIV/AIDS. The details of such moneys ranged from Le. Less than 20,000 to 200,000 depending on the type of services required and duration of such

services to be given. Data revealed that all the cadre in the care, treatment and support services interventions were part of this, from medical/health staff of all categories, social workers etc.

4.6 How many check-ups did you get in the last one month?

PLWHAs were asked how many checkups they get in the last one month of the research, the findings indicated that those that had one check-up and 2-3 check-ups had equal frequency of 38 times with 39.2 % each.

Table 4.36: How many check-ups did you get in the last one month?

	Frequency	Percent	Valid Percent	Cumulative Percent
1	38	39.2	39.2	39.2
2-3	38	39.2	39.2	78.4
4-5	9	9.3	9.3	87.6
Above 5	12	12.4	12.4	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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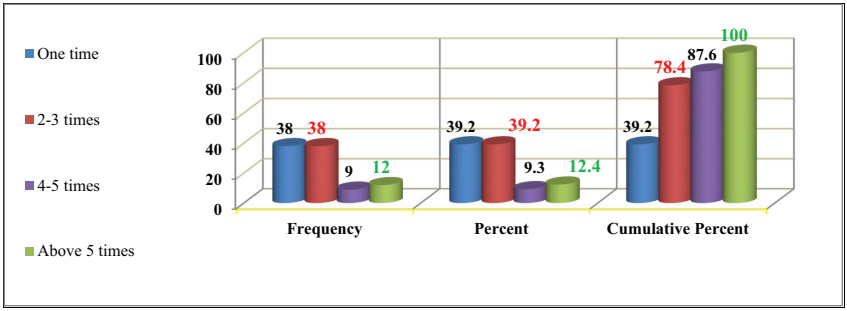
Participants who made 4-5 check-ups reported a frequency of 9 with 9.3% and those above 5 visits were 12 (12.4%) of the overall research population. After running cross tabulation, participants were disaggregated by self and parent/guardian. Participants that made one check-up were as follows; self 17 males and 17 females with 44.7% each and parents/guardian were 1 male (2.6%) and 3 females (7.9%). ***Note that just one check-up is not good.***

For 2-3 check-up, participants responded for self, had 12 males (31.6%) and 18 females (47.4%). Parents/ guardian had 3 males (37.5%), 5 females (62.5%). For 4-5 check-ups had 6 males (50%) and 5 females (41.7%), parents /guardian only had 1 female (8.3%)

Figure4.2.25: check-ups did you get in the last one month



Source: Author's data_2010

4.7 PLWHAs were seen by:

Overall, 61 (62.9%) of the 97 respondents were seen by a medical doctor, 11.3% were seen by a CHO and 25.8% seen by nurses.

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Table 4.37: Seen by:

		Frequency	Percent	Valid Percent	Cumulative Percent
	Doctor	61	62.9	62.9	62.9
	CHO	11	11.3	11.3	74.2
	Nurse	25	25.8	25.8	100.0
	Total	97	100.0	100.0	

Source: Author's data_2010

After cross tabulating data by participant and gender, the following results were obtained for those seen by doctors, self-responded participants, had 21 males (34.4%) and 33 females (54.1%); 2 males (3.3%) and 5 females (8.2%) were responded for by their parents / guardians. Overall, 23 males and 38 females were seen with 37.7% and 62.3% respectively.

Participants seen by CHOs had 5 males and 3 females who responded for themselves with percentage frequencies of 45.5% and 27.3% respectively. The other 3 participants whose parents

responded on their behalf had 2 males (18.2% and 9.1% respectively. Nurse also saw 25 of the respondents, of which 21 responded for themselves, in which, 11 were males accounting for 44.0% and 10 females representing 40.0%. The other 4 respondents were all females accounting for 16.0% whose parents responded for them.

4.8 Who did they refer you to?

Out of the 97 participants seen by the various levels of the health care providers 44(45.4%) were referred to a medical doctor, 40 (41.2%) were referred to hospital, 3 (3.1%) were referred to a specialized service and 10 (10.3%) were not referred at all.

Table4.38: Did they refer you to?

	Frequency	Percent	Valid Percent	Cumulative Percent
Doctor	44	45.4	45.4	45.4
Hospital	40	41.2	41.2	86.6
Specialized Services	3	3.1	3.1	89.7
None	10	10.3	10.3	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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On cross tabulation respondents were disaggregated by participants against gender by levels of referral: Doctors: 36.4% (16) of male and 56.8% (25) of female self-respondents were referred to a medical doctor. While only females 6.8% (3) were referred from participants whose parents or guardian responded for. For those referred to hospitals, equal numbers of participants (15 each) 37.5% of self-respondents were referred, and 3 males and 7females (7.5% and 17.5% respectively) who were responded for by parents or guardian were referred to a hospital.

Participants who were referred to specialized services accounted for 33.3% and 66.7% of males and females respectively of which all were self-respondents. None of the participants were represented either by parents or guardians, and finally, for self-respondents who were not referred

to any of the above accounted for 5 males and 4 females (50% and 40% respectively) and those whose parents or guardians responded for represented only 10% (just 1 male).

4.9 Were prescription (medicine) chart issued?

Overall, 95% received their prescription charts, which represents 93of the 97participants who consented to respond in the research. 4 (4.1%) of the 97 never received prescription charts.

Table 4.39: Prescription (medicine) chart issued?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	93	95.9	95.9	95.9
No	4	4.1	4.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

On cross tabulation of participants and gender, the analysis revealed the following: participants that responded for themselves had 36 males (38.7%) and 44 females (47.3%), and those whose parents or guardian responded for accounted for 4 males (4.3% and 9 females (9.7%).

Of the 4 (4.1%) participants who never received theirs charts and responded for themselves had 1 male (25%) and 2 females (50%). For those that were responded for by parents or guardian only had 1 female (25%) of the respondents in that variable.

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4.10 If yes, were all prescribed medicines issued?

Only 55.7% of those respondents whose charts were issued received all prescribed drugs, and 44.5% never received all drugs prescribed on their charts.

Table 4.40: If yes, all prescribed medicine were issued?

If yes, all prescribed medicine were issued?				
	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	54	55.7	55.7	55.7
No	43	44.3	44.3	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

On cross tabulation, those who responded for themselves and received all the medicines prescribed accounted for 21 males (38.9%) and 26 females (48.1%). 2 males and 5females (3.7% and 9.3% respectively) received all the medicines prescribed. The research also revealed that for those who never received or got all the prescribed drugs, submitted various reasons ranging from inadequate or lack of drugs at the facilities at the point in time; no moneys or insufficient funds to pay for the prescribed drugs.

4.11 Were all the health needs (what you came for) attended to?

Of the 20 care, treatment and support services and other health related needs and services outlined in the questionnaire, participants were at liberty to indicate which of those they visited the facilities for in the last one month. Against that backdrop only 55 of the 97 participants (56.7%) responded that they had all the services they visited those facilities for, and 42 (43.3%) said they never or partially had all they come for in the facilities.

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On cross tabulation, participants were disaggregated by gender, and of the 55 participants who received all services they visited they facilities for, 44 (87.3%) responded for themselves and 22 (40.0%) were males and 26 (47.3%) were females. 7(12.7%) of the participants were responded for by parents / guardian, of which 2(3.6%) were males and 5(9.1%) were females. Also of the 35(83.3%) who don't receive all their health needs who responded for themselves had 15 males (35.7%) and 20 females (47.6%). 7 (16.7%) participants who were responded for by parents /guardian had 2 males (4.8%) and 5 females (11.9%). Same reasons indicated above were submitted for not getting all their health needs as inadequate or lack of drugs at the facilities at the point in time; no moneys or insufficient funds to pay for the prescribed drugs.

4.12 Were the service(s) needed or to be used available?

Overall 92 (94.8%) of the participants said yes, that the services they needed were available every time they visited these facilities and only 5 (5.2%) responded in the negative.

Table 4.41: The service(s) that you use or need, are they available

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	92	94.8	94.8	94.8
No	5	5.2	5.2	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

Of those who said yes and responded for themselves 35 (38.0%) were males and 44 (47.8%) were females. Those 13 (14.1%) who were responded for by parents had 4 males (4.3%) and 9(9.8%) females. Of the 5 who responded in the negative, 4 responded for themselves, of which 2 (40.0%) were males and 2(40.0%) were females, and the only one (20%) who was responded for by parent was a female.

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4.13 Were you satisfied with the time(s) that those services were made available?

61.9% of the respondents (60) participants said they were satisfied with the waiting time and 38.1% (37) of participants responded in the negative. Out of the 37 who responded in the negative 100% said there were delays in service delivery at those facilities.

Table4.42: Are you satisfied with the time(s) that those services

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	60	61.9	61.9	61.9
No	37	38.1	38.1	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.14 Would you recommend someone to come to the clinic?

Out of the 97 participants, 92 (94.8%) responded in the affirmative and 5 (5.2%) in the negative.80.4%

Table 4.43: Would you recommend someone to come to the clinic?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	92	94.8	94.8	94.8
No	5	5.2	5.2	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

4.15 In your opinion, is there anything that you feel need attention or to be changed?

Of the 97 PLWHAs who participated in the study, 78 (80.4%) respondents said attention was needed on some of the services or interventions or even some needed to be challenged as indicated in the table below.

Table 4.44: In your opinion, is there anything that you feel need a change?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	78	80.4	80.4	80.4
No	19	19.6	19.6	100.0
Total	97	100.0	100.0	

Source: Author's data_2010

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On cross tabulation, 29 males (37.2%) and 38 (48.7%) females who responded for themselves said there is need for some changes, and 3 (3.8%) males and 8 (10.3%) females whose parents /guardian responded for also endorsed need for change, included addressing related problems with inadequate or lack of drugs at the facilities; no moneys or insufficient funds to pay for the prescribed drugs etc. 19 of the respondents indicated that there is no need for attention or change in any of the approaches in the facilities.

CHAPTER FIVE

5.0 CONCLUSIONS AND IMPLICATIONS

Purpose of this study was to evaluate the care, treatment and support services for PLWHAs within the Methodist Church Sierra Leone HIV/AIDS program in the western area of Sierra Leone. Evaluation was planned to investigate whether the services are accessible and utilized and to make recommendations to policy makers, programme planners and care givers based on the findings.

5.1 Summary of Research Findings

Of the 97 respondents from the MCSL program for PLWHAs, there were more females than males. Almost all were Sierra Leone citizens who traveled between 5-10km to the clinics or service delivery points. The majority were seen by nurses. The respondents indicated that they were to some extent satisfied with the service and their health needs were also partially met. They would recommend that people utilize the services that were provided and that improvement was needed or change in approach of care givers.

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5.2 Discussion of Summary

5.2.1 Demographic Data

Age

The majority of participants were females at the time of the study, 41(42.3%) were males and 56 (57.7%) were females (Table 4.3). the services attracted females most probably because of the kind of services offered, food, family planning, voluntary counseling and confidential testing, prevention of mother to child transmission, finance and ART are more female-orientated. There were no specialized male services, such as male circumcision or support men who have sex with men.

Distance

The study showed that in term of distance, the clinics or service provision points were not accessible as most of the participants lived within 5-10km (Table 4.10). according to the set norms and standards of the Basic Package of Essential Health Services and the Primary Health Care Services provision point or other health / medical facilities (The similarly, a study done by Bel et al. (2002, p44) in Namibia concluded that accessibility was said to be satisfactory as people in urban Windhoek traveled shorter distances to the clinic. Chatora and Tumusime (2004, p.299) pointed out that in sub-Saharan African, health centres were set up so that people in the catchment area would not travel more than 8km or one hour travel time to access the nearest health facility.

Traveling time

A significant proportion of participants reported to have traveled 30-60 minutes to the clinics or service delivery points. Others traveled for more than one hour and only a minority traveled for 30 minutes or less (Figure 4.7). The current study revealed that the MCSL clinics and services delivery points are less accessible as most respondents (79%) indicated that they have traveled more than 30 minutes to the facilities.

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Means of transport

The results indicated that the more common form of transport that the respondents used to access care, treatment and support services was the taxi 39.2%. The second from was bus 30.9%, with only 2 (2.1%) people using their own transport, and 25.8% of the respondents walked. Some individuals reported having walked very long distance or long times because they were too poor to afford the fare. Public transport usage and walking were the most popular mode of transport to access the care, treatment and support services.

5.2.2 Service Information

The results of this study revealed that condom provision was most accessed. Generally, the current study found that the care, treatment and support services needs of PLWHAs were met at some level (Table 5.1). They PLWHAs that were not satisfied stated amongst others, that because of lack of financial resources, inadequate drugs and other supplies and the behaviour of some of the care givers. The following examples were cited: staff shortages; slow service delivery, negative attitude of care, treatment and support staff, and other services, such as testing, family planning and treatment of STIs not being available for 24 hours. Despite those care, treatment and support barriers, a significant number of participates 92 of the 97 (94.8%) (Table 4.43) said they would recommend to a friend or family to utilize the clinics or service delivery points when sick.

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5.2.3: Utilization of Services at the Clinics and Service Delivery Points

The survey revealed that all the services provided at the clinics and service delivery point were utilized, i.e. financial assistance, food and nutritional support, medical services, VCCT services, PMTC services, ART services, STI treatment, Condom promotion etc. condom promotion was mostly utilized, probably due to the fact that most people who utilized the clinic and service provision points were between ages 16-25 through to 36-45 year, age groups in which youth are dominant.

5.3 Recommendations

Based on the findings of the current research, the following recommendations are made which could be implemented to further improve the accessibility and utilization of care, treatment and support services for people living with HIV/AIDS.

- The ministry of Health and Sanitation in collaboration with the National points for PLWHAs in the Western region; these should be open for 24 hours and render all care, treatment and support services.

- More doctors, CHOs and especially nurses should be appointed at the existing clinics and service delivery points since most of the PLWHAs are seen by nurses.
- Wages of staff be improved and professional development be encouraged, i.e. to train more CHOs and nurse as care, treatment and support practitioners and specialize in their field of interest. This would improve quality of care interventions.
- The National HIV/AIDS secretariat and its implementing partners should develop and implement an Home Based-Care Programme (Programme offered by care givers to help PLWHAs to deal with their personal problems e.g. counseling treatment of STIs, provision of ARTs, food and nutritional support services etc.), which might help to eliminate unfriendly and uncaring behaviour of other health care personnel.
- The government through the national HIV/AIDS secretariat should subsidize services, such as a bus service to and from the clinics or services delivery points for PLWHAs, plus laboratory tests and other services since everybody has a right to health.
- The National HIV/AIDS Secretariat and the Ministry of Health and Sanitation should ensure that no health professional or care, treatment and support staff demand moneys from PLWHAs before, during or after rendering services. This might contribute to increased utilization of services and also mitigate the negative impact on those infected or affected by the virus, their families, communities and the nation as a whole.

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5.4: Conclusion

According to the Constitution of Sierra Leone, 1991, everyone has the right to have access to health care services. The Primary Health Care approach was adopted in order to promote accessibility to the use of health services and also to respond to the call of the World Health Organization, 'Health for all by the year 2000', and therefore Primary Health Care is rendered free of charge in Sierra

Leone to all lactating mothers, children under five years of age and pregnant women. Secondly, according to the revised National HIV/AIDS Policy – 2007, care, treatment and support services should be made accessible to PLWHAs and fully utilized by them on a free basis. Overall, the result of the study were positive in that it was indicated that the Care, treatment and support services in MCSL operational areas were accessible and utilized at different levels.

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ANNEXURES

Questionnaire

Introduction: My name is **James L. Kamara**; I'm a student at the Njala University, pursuing a Master's degree in Public Health (MPH). I would be most grateful for your time for me to administer this questionnaire he help me complete the conduct of my dissertation. I had personally worked with the National HIV/AIDS Secretariat as Monitoring and Evaluation Officer for over six years.

Confidentiality and consent: "I'm going to ask you some very personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help me better understand what you think, say and do about certain kinds of Care, Treatment and Support services with regard to PLWHAs. I would greatly appreciate your help in responding to this survey. The survey will take about 40 minutes to ask the questions. ***Would you be willing to participate?"***

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_____ (Signature of interviewer certifying that informed consent has been given verbally by respondent)

QUESTIONS

Name of Organisation: Date:

DEMOGRAPHIC AND OTHER RELATED DATA:

1. Participant:

1=Self	2=Parent/guardian

2. Age:

1=Under 5 years	2= 6-15 years	3= 16-25 years	4= 26-35 years	5= 36-45 years	6= 46-55 years	7= 56-65 years	8= Above 65 years

3. Gender:

1=Male	2=Female

4. What is your religion?

1=Christian	2=Muslim	3=Baha'i	4=Others	5=Non

5. Are you a Sierra Leonean citizen?

1=Yes	2=No

6. What is the highest level of school you attended, if at all?

CIRCLE ONE ONLY

1=Never Attended School	2=Primary	3=Tech-Voc	4=Vocational	5=Junior Secondary	6=Senior Secondary	7=Higher	8=Other (specify)

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7. What is your main occupation?

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1= Farmer	2= Civil servant	3= Truck driver	4= Trader	5= Police	6= Military	7= House wife	8= Nurse	9= CSW	10= Student	11= Other (specify)

8. What is your marital status?

1=Single	2=Married	3=Divorced	4=Separated

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9. What was the cause of your infection?

1=From spouse: infected by IDU	**2=From spouse:** infected by CSW	3= Through IDU	4= Through CSW	5= Blood transfusion	6= Unknown

10. Are you on ART treatment? 1=Yes, 2=No

11. What distance do you travel to the service provision point or clinic?

12. How long does it take you to reach the service provision point / centre?

1=Less than 5 km	2=5 – 10 km	3=More than 10 km

1=30 min or less	2=30min – 1hr	3=More than 1hr

13. Means of transport:

1=walk	2=taxi	3=bus	4=okada	5=Own transport

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Service utilisation at provision points / clinic information:

14. Reason(s) for coming to and levels of satisfaction / utilisation of services from the service provision or delivery points / clinics / centers:

14.1 You or child infected with HIV: 1=Me, 2=Child

Why did you come to the service provision or delivery points and what was your level of satisfaction?

	Reasons why you visited the service delivery point	Yes=1 No=2	Level of satisfaction / utilisation (codes)
14.2	Finance		
14.3	Food		
14.4	T.B treatment		
14.5	Medical		
14.6	Vocational training		

14.7	Family planning		
14.8	Education		
14.9	Legal		
14.10	VCCT		
14.11	PMTCT		
14.12	ART		
14.13	HBC		
14.14	STI		
14.15	Condom		
14.16	Housing		
14.17	Clothing		
14.18	Sponsorship		
14.19	Recreation		
14.20	OVC		

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Codes for level of satisfaction/ utilisation: *1= VERY DISSATISFIED 2= DISSATISFIED 3= NEITHER SATISFIED NOR DISSATISFIED 4= SATISFIED 5= VERY SATISFIED*

14.21 Do you pay money for any of the above services or intervention before receiving it?

Which services did | 1=Yes | 2=No | you pay for, to whom did you pay and how much did you pay

Service	**To whom**	**Amount paid (in Le)**
Finance		
Food		

T.B treatment		
Medical		
Vocational training		
Family planning		
Education		
Legal		
VCCT		
PMTCT		
ART		
HBC		
STI		
Condom		
Housing		
Clothing		
Sponsorship		
Recreation		
OVC		

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Code for the person paid to: ***1***= *Med. Doctor,* ***2***= *CHO,* ***3***= *Nurse,* ***4***= *Counselor,* ***5***= *Lab. Tech,* ***6***= *Social worker,* ***7***= *HBC Giver,* ***8***= *other (specify)*

Code for amount: ***1***= *Less than Le. 20,000,* ***2***= *Le. 20,000 to 50,000,* ***3***= *Le. 50,000 to 100,000,* ***4***= *Le. 100,000 to 200,000,* ***5***= *Le. 200,000 to 300,000,* ***6***= *Le. 300,000 to 400,000,* ***7***= *Le. 400,000 to 500,000,* ***8***= *Le. 500,000 and above*

15. How many check-ups did you get in the last one month?

1=1	2=2-3	3=4-5	4=Above 5

16. Seen by:

1=Doctor	2=CHO	3=Nurse

17. Did they refer you to?

1=Doctor	2=Hospital	3=Specialized Services	4=None

18. Prescription (medicine) chart issued

1=Yes, 2=No

18.1 If yes, were all prescribed medicine issued?

1=Yes, 2=No

18.2 If no, why? .....

19. Were all your health needs (what you came for) attended to?

1=Yes, 2=No

19.1 If no, give reason(s): …….

……

20. The service(s) that you use or need, are they available every time you visit the clinic? 1=Yes, 2=No

21.1 If no, give reason(s): …….

22. Are you satisfied with the time(s) that those services are available?

1=Yes, 2=No

22.1 If no, give reason(s): …….

……..

23. Would you recommend someone (friend / family) to come to the clinic when sick?

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1=Yes, 2=No

23.1 If no, give reason(s): ……...

……

24. In your opinion, is there anything that you feel need attention or to be changed?

1=Yes, 2=No

24.1 If yes, give details: ……

……....

……..

I THANK YOU VERY MUCH FOR YOUR SUPPORT AND RESPONSES_JLK

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